Student Health Insurance

Designed for the Undergraduate and Graduate Students of

UCONN UNIVERSITY OF CONNECTICUT

Storrs Campus
Regional Campus
2015-2016

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH
Policy Number: 302-123-0613

Effective: August 15, 2015 to August 14, 2016
Group Number: S200595

IMPORTANT NOTICE
This brochure provides a brief description of the important features of the Policy. It is not a Policy. Terms and conditions of the coverage are set forth in the Policy. We will notify Covered Persons of all material changes to the Policy. Please keep this material with your important papers.

NONSERIMINATORY
Health care services and any other benefits to which a Covered Person is entitled are provided on a nondiscriminatory basis, including benefits mandated by state and federal law.

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WHERE TO FIND HELP

The University of Connecticut Student Health Insurance Plan has been developed especially for The University of Connecticut students for the Regional and Storrs Campus. The Plan provides coverage for Sicknesses and Injuries that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. The University of Connecticut is pleased to offer the Plan as described in this brochure.

For Questions About: Please Contact:

Waiver Process The University of Connecticut
Health Services
Student Health Services
234 Glenbrook Road, Unit 2011
Storrs, CT 06269-2011
(860) 486-4456
Email: www.shs.uconn.edu

Dependent Enrollment Bailey Agencies, Inc.
15 Thames Street
Groton, CT 06340
Phone: 860-446-8255 or 800-321-4449
Fax: (860) 448-1608
www.baileyagencies.com/college.html

Insurance Benefits Consolidated Health Plans
Preferred Provider Listings
2077 Roosevelt Avenue
Springfield, Massachusetts 01104
(800) 633-7867
www.chpstudent.com

Preferred Provider Listings
Claims Processing
Id Card Requests
Consolidated Health Plans or
http://hcpdirectory.cigna.com/web/public/providers

Prescription Drug Providers
Catamaran
www.mycatamaranrx.com

THE UNIVERSITY OF CONNECTICUT
STUDENT HEALTH INSURANCE PLAN

This is a brief description of the Injury and Sickness Medical Expense benefits available to The University of Connecticut students. The Plan is underwritten by Nationwide Life Insurance Company. If you are covered by this plan, you will be covered 24 hours a day, on or off campus, throughout the United States and around the world. The exact provisions governing this insurance are contained in the Master Policy. See the University for additional information. The Plan is administered by Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield, Massachusetts, 01104.

UCONN STUDENT HEALTH SERVICES (SHS)
STORRS CAMPUS ONLY

234 Glenbrook Road, Storrs, CT 06269-4011
Phone (860) 486-4700
Emergencies call 911
Or
Campus Police (860) 486-4800

HOURS OF OPERATION

| When Classes are in Session | Monday – Friday | 8:00 a.m. – 10:30 p.m. |
| When Classes are in Session | Saturday & Sunday | 8:00 a.m. – 3:30 p.m. |
| Summer & School Breaks | Monday – Friday | 8:30 a.m. – 4:30 p.m. |
| Advice Nurse When Classes are in Session | Monday - Sunday | 24 Hours |
| Summer & School Breaks | Saturday & Sunday | CLOSED |

The UConn SHS is the University’s on-campus health facility. Health Services is staffed by a physician, nurse practitioners and registered nurses.

Any student who has paid the General University Fee is eligible to use Health Services. Students who are registered for credit-bearing courses at Storrs through the College of Continuing Studies are also eligible.

The SHS provides a wide variety of services. This includes primary care visits with doctors, nurse practitioners, nurses and nutritionist. Additional charges may be incurred for laboratory testing, pharmacy items, X-rays, special medical procedures and visits with specialists. The Women’s Clinic also charges for annual GYN exams. Many of the charges are reimbursable by this Plan or other private health insurance.

AM I ELIGIBLE?

The University of Connecticut is making available a Student Health Insurance program (hereinafter called “plan”) underwritten by Nationwide Life Insurance Company and administered by Consolidated Health Plans. This brochure provides a general summary of the insurance coverage; the Schedule of Benefits is not all inclusive of eligible benefits payable under this plan. Keep this brochure as no individual policy will be issued. This summary is not a contract; however, the Master Policy will be available for review upon request. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

All full-time undergraduate (12 or more credits) and graduate (9 or more credits) students are required to be covered under the UConn Student Health Insurance Plan, unless they have demonstrated through completion of an Online Waiver, that they are covered under a health insurance policy that provides equal or better benefits than the insurance program offered by the University of Connecticut. Part-time students taking a minimum of six (6) credits of class attended course work are eligible to voluntarily enroll in the plan. Part-time students should contact Bailey Agencies, Inc. to complete the enrollment.
Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium, minus any claims paid.

**HOW DO I WAIVE?**

Most full-time students will be automatically enrolled in the Student Health Insurance Plan, unless a waiver has been completed by the specified deadline dates listed. The premium for the Plan will be added to your tuition bill. Eligible students who enroll may also insure their eligible dependent(s). To enroll dependent(s), please contact the Bailey Agencies Inc., 15 Thames Street, Suite 100, Groton, CT 06340, 860-446-8255 or toll free at 1-800-321-4449.

**Exempt Programs:** While most full-time students are automatically billed for the UConn Student Health Insurance Plan, there are some university programs that are exempt from the health insurance requirement. Due to multiple changes of program classification it is advised that ALL students check their tuition fee bill to determine if the fee for the insurance has been posted. If the change has not been posted, you may still be eligible to voluntarily enroll in the student health insurance plan.

If after review of the coverage a student wants to formally decline (waive) the CHP/UConn Student Health Insurance Plan, on online waiver must be completed. The online Waiver is accessed through the student administration (PeopleSoft) system at www.studentadmin.uconn.edu. Your UConn NetID number and unique password are needed to access the system. The only acceptable form of notification to decline the coverage is via the online waiver.

The deadlines to waive coverage are:

- **Fall/Annual Plan - September 15, 2015**
- **Spring Term (new students only) - February 05, 2016**

If you submit an online waiver for the Fall Semester, coverage is automatically waived for the Spring semester; you don’t need to submit the waiver again. Only new or transfer students need to complete the online waiver request for the Spring semester.

Waiver submissions may be audited by the University of Connecticut, the Bailey Agencies, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school’s requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school’s waiver requirements.

**COVERAGE FOR DEPENDENTS**

Insured Students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents. Eligible dependents under the plan include the Insured person’s spouse/domestic partner/including a party to a civil union residing with the insured and dependent children under age twenty-six (26). Dependent Eligibility expires concurrently with that of the Insured Student.

To enroll the dependent(s) of an eligible student, please contact Bailey Agencies, Inc. directly at (860) 446-8255 or toll free at (800) 321-4449 or go to online at: http://www.baileyagencies.com/college.html. Payment of the premium for dependents is due in full and the acceptable forms of payment are cash, check, money order and/or credit card.

The fall enrollment deadline is **September 15, 2015** and **February 5, 2016** for the spring enrollment. The dependent enrollment application will not be accepted after the fall or spring enrollment deadlines, unless there is a significant life change that directly affects their insurance coverage, such as loss of health coverage under another health plan.

Students may also enroll their Dependent newborn child within sixty-one (61) days (spouse within thirty-one (31)) of an eligible qualifying event. Eligible qualifying events for a Dependent are defined in the Master Policy. Enrollment requests (including payments) received after the required number of days following the qualifying event will not be accepted. Coverage will be effective as of the date of the qualifying event.

**EFFECTIVE DATES AND COSTS**

1. **Students:** Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on August 15, 2015, and will terminate at 12:01 a.m. on August 15, 2016.

2. **New Spring Semester Students:** Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a.m. on January 1, 2016, and will terminate at 12:01 a.m. August 15, 2016.

3. **Insured Dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premiums are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions as described in the Master Policy. Examples include, but are not limited to, the date the Insured student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

<table>
<thead>
<tr>
<th></th>
<th>Annual 8/15/15 – 8/15/16</th>
<th>Spring 1/1/16 – 8/15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student</strong></td>
<td>$2,947</td>
<td>$1,864</td>
</tr>
<tr>
<td><strong>Dependent rates are in addition to the student rate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Dependent</td>
<td>$2,922</td>
<td>$1,839</td>
</tr>
<tr>
<td>2 Dependents</td>
<td>$5,844</td>
<td>$3,678</td>
</tr>
<tr>
<td>Family (3+)</td>
<td>$8,766</td>
<td>$5,517</td>
</tr>
</tbody>
</table>

*All costs above include a fee retained by the Servicing Agent.
TERMINATION

Coverage will terminate at 12:01 a.m. standard time at the Policyholder’s address on the earliest of:

- The Termination Date of the Policy; or
- The last day of the term of Coverage for which Premium is paid; or
- The date a Covered Person enters full time active military service. Upon written request within 90 days of leaving school, We will refund the unearned pro-rata Premium to such person; or
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined.

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the termination date, shown on the face page. However, if a Covered Person is:

1. Hospital Confined on the Termination Date from a covered Injury or Sickness for which Benefits were paid before the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of thirty (30) days or until date of discharge, whichever is earlier.
2. Being treated on the Termination Date for an Injury or Sickness for which Benefits were paid under this Policy prior to the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of thirty (30) days or until the Injury or Sickness ends, whichever is earlier.
3. Totally Disabled on the Termination Date from a covered Injury or Sickness for which Benefits were paid before the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of ninety (90) days or until the date the disability ends, whichever is earlier.

Totally Disabled means, with respect to the Insured, the inability to attend classes at the location where he is enrolled. With respect to a Dependent, or the Insured if such classes are not in session, disability means the inability to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the Covered Person immediately prior to the Injury or Sickness.

The total payments made in respect of the Covered Person for such Condition both before and after the termination date will never exceed the Maximum Benefit. After this Extension of Benefits provision has been exhausted, all Benefits cease to exist and under no circumstances will further Benefits be made.

Dependents that are newly acquired during the Insured’s Extension of Benefits period are not eligible for Benefits under the provision.

PREMIUM REFUND POLICY

Any Insured Student withdrawing from the college during the first thirty-one (31) days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made minus any claims. Students withdrawing after thirty-one (31) days will remain covered under the Policy for the full period for which premium has been paid and no refund will be made available. This is true for students on leave for medical or academic reasons, graduating students, and students electing to enroll in a separate comparable plan during the Policy Year. Premiums received by the Company are non-refundable except as specifically provided.

Covered Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person upon written request received by the Company within ninety (90) days of withdrawal from school. Refunds for any other reason are not available.

PRE-CERTIFICATION PROCESS

The Schedule of Benefits identifies medical Covered Services which must be Pre-Certified by the Review Organization. Advising the Review Organization before You receive such medical Covered Services allows the Review Organization to determine Medical Necessity and Medical Appropriateness. Medical care that is not necessary and appropriate adds to the cost of care and exposes You to unnecessary risk.

Failure to comply with the Pre-Certification process requirements will result in a Pre-Certification penalty. Such penalty amount is payable even though Deductible and Out-of-Pocket Maximum amounts have been met. The Pre-Certification penalty is listed in the Schedule of Benefits.

You are responsible for calling the Review Organization at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services, the call must be made at least three (3) - five (5) working days prior to Hospital Confinement. In the case of an Emergency, the call must take place within two (2) working days of admission.

The following Inpatient and Outpatient services or supplies require Pre-Certification:

- All Inpatient admissions, including length of stay, to a Hospital, convalescent facility, Skilled Nursing Facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility; or
- All Inpatient maternity care after the initial 48/96 hours.

Pre-certification is not a guarantee that Benefits will be paid.

Your Physician will be notified of the Review Organization’s decision as follows:

- For elective (non-Emergency) admissions to a Health Care Facility, the Review Organization will notify Your Physician and the Health Care Facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
- For Confinement in a Health Care Facility longer than the originally approved number of days, Your treating Physician or the Health Care Facility must contact the Review Organization before the last approved day. The Review Organization will review the request for continued stay to determine Medical Necessity and...
notify the Physician or the Health Care Facility of its decision in writing or by telephone;

- For any other Covered Services requiring Pre-Certification (identified in the schedule of Benefits), the Review Organization will contact the Provider in writing or by telephone regarding its decision.

Our Review Organization agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non-urgent requests following receipt of all necessary information for review. Notice of an adverse determination made by the Review Organization agent will be in writing and will include:

- The reasons for the adverse determination including the clinical rationale, if any.
- Instructions on how to initiate standard or urgent appeal.
- Notice of the availability, upon request of the Covered Person, or the Covered Person's designee, of the clinical review criteria relied upon to make the adverse determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, the Review Organization Agent in order to render a decision on any requested appeal.

Failure by the Review Organization agent to make a determination within the time periods prescribed shall be deemed to be an adverse determination subject to appeal. If You have questions about Your Pre-Certification status, You should contact Your Provider.

### SCHEDULE OF BENEFITS

Your Coverage provides for the utilization of Preferred Providers in a Preferred Provider Organization (PPO). The Preferred Provider Organization(s) for your Coverage is: Cigna Go to www.Cigna.com for a list of participating providers.

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible, per Covered Person</td>
<td></td>
</tr>
<tr>
<td>Deductible is waived:</td>
<td>$400</td>
</tr>
<tr>
<td>- At UConn-SHS;</td>
<td></td>
</tr>
<tr>
<td>- For Outpatient Laboratory Expenses;</td>
<td></td>
</tr>
<tr>
<td>- For In-Network Prescriptions; and</td>
<td></td>
</tr>
<tr>
<td>- For Preventative/Wellness &amp; Immunization Services.</td>
<td></td>
</tr>
</tbody>
</table>

| Out-of-Pocket Maximum (includes Coinsurance and Copayments; does not include Precertification penalty, non-covered medical expenses, or elective treatment) | $6,600 Individual | $13,200 Family |

| Insured percent | 90% of Preferred Allowance (PA) | 70% of Reasonable & Customary (R&C) |

| Pre-certification penalty | the lesser of 50% of the Benefit or $500 |

| Outpatient Services | Office Visits (includes Specialists), benefits are limited to one (1) visit per day and do not apply when related to surgery or psychotherapy. (Co-pay and Deductible waived at UConn-SHS) | $40 co-pay per visit, then 100% of PA | 70% of R&C |
| Diagnostic Imaging, X-ray and Laboratory Services | 90% of PA | 70% of R&C |
| High Cost Procedures include: | 90% of PA | 70% of R&C |
| - Computed Axial Tomography (C.A.T. Scan); | |
| - Magnetic Resonance Imaging (MRI); | |
| - Positron Emission Tomography (PET Scan); | |
| - Contrast Materials for these tests. | |

| Inpatient Services (Precertification Required) | Miscellaneous Hospital Services includes meals and prescribed diets, Diagnostic Imaging, Laboratory, pharmaceuticals administered while an Inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical event, Pre-Admission Testing and Inpatient Rehabilitation. | 90% of PA | 70% of R&C |
| Room and Board expense, at the semi-private room, general nursing care, and ICU. | 90% of PA | 70% of R&C |
| Physician visits (includes Specialists/Consultants), benefits are limited to one (1) visit per day and do not apply when related to surgery. | 90% of PA | 70% of R&C |
| Skilled Nursing and Sub-Acute Care Facilities | 90% of PA | 70% of R&C |
| Surgical Services (Inpatient & Outpatient) | | |
| Surgeon’s Fee | 90% of PA | 70% of R&C |
| Assistant Surgeon, limited to 20% of Surgeon’s payment | 90% of PA | 70% of R&C |
| Anesthetist Services | 90% of PA | 70% of R&C |
| Surgical miscellaneous includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event. | 90% of PA | 70% of R&C |
| Other Surgical Services | | |
| Organ transplants | 90% of PA | 70% of R&C |
| Second Surgical Opinion | $40 co-pay, then 100% of PA | 70% of R&C |
### Acupuncture in Lieu of Anesthesia
must be administered by a health care provider who is legally qualified physician, practicing within the scope of their license.

<table>
<thead>
<tr>
<th>Service</th>
<th>PA Coverage</th>
<th>R&amp;C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture in Lieu of Anesthesia</td>
<td>90%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### Reconstructive surgery

<table>
<thead>
<tr>
<th>Service</th>
<th>PA Coverage</th>
<th>R&amp;C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided.</td>
<td>90%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### Maternity Care

- **90% of PA**
- **70% of R&C**

### Pre and post-natal services

- Paid the same as any other Sickness

### Home Health Care

- **90% of PA**
- **70% of R&C**

### Hospice

- **90% of PA**
- **70% of R&C**

### Hearing Aids

- Maximum Benefit: One (1) hearing aid, every twenty-four (24) months.
- Coverage is also provided for cochlear implants.

### TMJ – oral surgical services for the treatment of tumors, cysts, injuries of the facial bones and for the treatment of fractures and dislocations involving the face and jaw, including TMJ dysfunction surgery (for demonstrable joint disease only), or temporomandibular disease (TMD) syndrome.

- **90% of PA**
- **70% of R&C**

### TMD – oral surgical services for the treatment of tumors, cysts, injuries of the facial bones and for the treatment of fractures and dislocations involving the face and jaw, including TMJ dysfunction surgery (for demonstrable joint disease only), or temporomandibular disease (TMD) syndrome.

- **90% of PA**
- **70% of R&C**

### Sleep studies (limited to one (1) study per lifetime).

- **90% of PA**
- **70% of R&C**

### Genetic Testing – Provided only when a Covered Person is suspected of having a clinical genetic disorder and provided when a Covered Person is undergoing IVF, GIFT, or ZIFT if the embryos are at risk for known genetic mutations.

- **90% of PA**
- **70% of R&C**

### Diabetic treatment and Education

- Paid the same as any other Sickness

### Durable Medical Equipment (DME) – includes Prosthetic and Orthotic Devices

- **90% of PA**
- **70% of R&C**

### Ostomy Appliances and Supplies

- **90% of PA**
- **70% of R&C**

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### Table 1

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre and post-natal services</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td>Urgent Care Service</td>
<td>$40 co-pay per visit, then 100% of PA</td>
</tr>
<tr>
<td>Emergency services. Use of the emergency room and supplies. (Co-payment waved if admitted) If Policy Year Deductible has not yet been met, then the In-Network Deductible would apply to an Out-of-Network visit.</td>
<td>$150 co-pay per visit, then 100% of PA</td>
</tr>
<tr>
<td>Walk-In Clinic Visit Expense</td>
<td>$40 co-pay per visit, then 100% of PA</td>
</tr>
<tr>
<td>Other Services</td>
<td>100% of Actual Charge</td>
</tr>
<tr>
<td>Preventive/Wellness &amp; Immunization Services (deductible waived)</td>
<td>100% of PA</td>
</tr>
<tr>
<td>Allergy Services (testing/injections/treatment)</td>
<td>90% of PA</td>
</tr>
<tr>
<td>Habilitative therapy – including Physical, Speech, and Occupational</td>
<td>$40 co-pay per visit, then 100% of PA</td>
</tr>
<tr>
<td>Rehabilitative therapy – including Physical, Speech, and Occupational. (Speech therapy limited to 40 visits per policy year)</td>
<td>$40 co-pay per visit, then 100% of PA</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>$40 co-pay per visit, then 100% of PA</td>
</tr>
</tbody>
</table>
### Prescription Drug Expense
- Only a thirty (30) day supply can be dispensed at any time.
- One (1) co-payment per thirty (30) day supply.
- Three (3) co-payments per ninety (90) day supply.
- Co-pay does not apply to generic contraceptives.
- Co-payments apply to the out-of-pocket.
- Prescriptions should be filled at a Catamaran participating pharmacy. Go to www.mycatamaranrx.com for a list of participating pharmacies.

<table>
<thead>
<tr>
<th>Prescription Drug Expense</th>
<th>100% after a: $0 copayment for Generic Contraceptives; or $5 Co-pay for Preferred Brand drugs; or $40 Co-pay for Preferred Brand drugs; or $60 Co-pay for Non-Preferred Brand drugs.</th>
<th>100% after a: $5 Co-payment for Generic Drugs; or $40 Co-pay for Preferred Brand drugs; or $60 Co-pay for Non-Preferred Brand drugs.</th>
</tr>
</thead>
</table>

Note: Policy year deductible does not apply.

### Routine Vision Exam for Covered Persons under nineteen (19) – limited to one (1) exam per Policy Year. Includes prescription eyeglasses (lenses & frames) limited to once per Policy Year. 100% of R&C up to $150, 50% thereafter.

### Pediatric Dental & Vision for under age nineteen (19)
- Preventive/diagnostic services – 100% of R&C
- Basic restorative services – 70% of R&C
- Major services – 50% of R&C
- Medically Necessary orthodontia services – 50% of R&C* *prior authorization required

### Elective Services (do not apply to the Out of Pocket maximum)

<table>
<thead>
<tr>
<th>Service</th>
<th>100% of Actual Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Evacuation/Repatriation</td>
<td>100% of Actual Charges</td>
</tr>
<tr>
<td>Family Travel Benefit</td>
<td>100% of Actual Charges up to $5,000</td>
</tr>
<tr>
<td>Gender Reassignment Surgery</td>
<td>Paid the same as any other Sickness</td>
</tr>
<tr>
<td>Non Emergency treatment outside the United States</td>
<td>70% of R&amp;C</td>
</tr>
<tr>
<td>Intramural and Club Sports</td>
<td>90% of PA, 70% of R&amp;C</td>
</tr>
<tr>
<td>Elective termination of pregnancy, up to a maximum benefit of $400 per procedure</td>
<td>90% of PA, 70% of R&amp;C</td>
</tr>
<tr>
<td>Voluntary Sterilization surgery: Note: Sterilization procedures for women are covered under Preventive</td>
<td>100% of PA, 70% of R&amp;C</td>
</tr>
<tr>
<td>Dental Treatment due to injury to a sound natural tooth, up to a maximum benefit of $250 per tooth, per injury, per Policy Year.</td>
<td>90% of actual charges</td>
</tr>
<tr>
<td>Dental treatment for impacted wisdom teeth</td>
<td>90% of actual charges</td>
</tr>
<tr>
<td>Intramural and Club Sports</td>
<td>90% of PA, 70% of R&amp;C</td>
</tr>
<tr>
<td>Licensed Nurse Expense</td>
<td>90% of PA, 70% of R&amp;C</td>
</tr>
</tbody>
</table>

### Accidental Death & Dismemberment

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefit Amount Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$10,000</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>$5,000</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>$5,000</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

Note: Loss shall mean, with regard to hands, or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint. Only the largest benefit will be paid if more than one loss results from any one Accident.

### MANDATED BENEFITS
If You are enrolled in this Insurance Program, Policy coverage also includes the following benefits. (Note: Wellness/preventive benefits under the Affordable Care Act (ACA) are required to meet federal regulations. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate. Please see the Schedule of Benefits for coverage details.)

- Accidental Ingestion of Controlled Drugs
- Ambulance Services Benefit
- Amino Acid Modified Preparation and Low Protein Modified Food Products
- Antigen testing
- Autism Spectrum Disorder
- Cancer drugs
- Chiropractic Care
- Clinical Trials
- Colorectal Cancer Screening
- Contraceptives
- Coverage for Newborns
- Craniofacial Disorders
- Cytological Screening
- Diabetes Outpatient Management training and treatment
- Diagnosis and Treatment of Infertility
- Early Intervention
- Elevated Blood Alcohol Content
- Epidermolysis Bullosa
- Experimental Treatments
- Home Health Care
- Hypodermic Needles or Syringes
- In-hospital dental services
- Isolation Care and Emergency Services
- Lyme Disease Treatment
- Mammography Examination
- Mastectomy or Lymph Node Dissection
- Maternity Benefits and Postpartum Care
- Medical Complications of Alcoholism
- Mental or Nervous Disorder/Drug Abuse/Alcoholism
- Neuropsychological Testing
- Off Label Drugs
- Occupational Therapy
- Ostomy Appliances and Supplies
- Obstetric and Gynecological Services
- Pain Management
- Pediatric Preventive
- Prescription Eye Drop
- Prostate Cancer Screening
- Psychotropic Drug Availability
- Treatment of Leukemia
- Removal of Tumors

### PREFERRED PROVIDER INFORMATION
By enrolling in this Insurance Program, you have the Cigna PPO Network of Participating Providers, providing access to quality health care at discounted fees. To find a complete listing of Cigna PPO Network of Participating Providers, go to www.cigna.com, or contact Consolidated Health Plans at (413) 733-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. If care is received within the Network from a Preferred Provider, all Covered Medical Expenses will be paid at the Preferred Provider level of benefits found on the Schedule of
Benefits. In the case of an Emergency, if an Out-of-Network Provider is used, the In-Network percentage in the Schedule of Benefits will be applied. A Covered Person is not required to seek treatment from a Preferred Provider. Each Covered Person is free to elect the services of a Provider and Benefits payable will be made in accordance with the terms and Conditions of this benefit.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"Out-of-Network" providers have not agreed to any prearranged fee schedules. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

**PRIMARY PROVISION**

This provision applies if a covered student is covered by any other group or blanket health care plan, and if their parents or guardians pay any portion of the premium for this plan. In this case, this plan will always pay primary without regard to any other payer's payment.

**SUBROGATION AND RECOVERY RIGHTS**

If we pay Covered Expenses for an Accident or Injury you incur as a result of any act or omission of a third party, you are obligated to reimburse Us for the expenses paid. We may also take subrogation action directly against the third party. Our reimbursement rights are limited by the amount you recover. Our reimbursement and subrogation rights are subject to deduction for the pro-rata share of your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

**EXCLUSIONS**

Unless specifically included, no Benefits will be paid for: a) Loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. Eyeglasses, contact lenses, routine eye refractions, eye examinations except as in the case of Injury or Sickness. Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.
2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids (except as provided herein) and the fitting or repairing of hearing aids.
3. Vaccines and immunizations (except as specifically provided in the Policy): a) required for travel; and b) required for employment.
4. Treatment (other than surgery) of chronic Conditions of the foot including weak feet, fallen arches, flat foot, pronated foot, care of corns, calluses, and toenails.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease or for treatment of an injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; hair growth; hair removal; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants including gynecomastia (except for correction or deformity resulting from mastectomies or lymph node dissections); rhinoplasty; nasal and sinus surgery; except when Medically Necessary for treatment of acute purulent sinusitis. This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part.

6. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by the person’s Attending Physician or dentist.

7. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications. Upon written request, claims denied under this provision may be reviewed by an independent medical review entity if You or Your Dependent has a terminal Condition that, according to the Physician’s current diagnosis, has a high probability of causing death within 2 years from the date of the request for medical

8. Custodial Care; Care provided in a: rest home, home for the aged, halfway house, health resort, or any similar facility for domiciliary or Custodial Care.

9. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, (except as specified herein).

10. Injury sustained while (a) participating in any intercollegiate, professional, semi-professional sport, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition.

11. Injury sustained by reason of a motor vehicle Accident to the extent that Benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such Benefits.

12. Injury occurring in consequence of riding as a passenger or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline, or as a passenger in a Policyholder owned, leased, chartered, or operated aircraft.

13. Sterilization reversal.

14. Hospital Confinement or any other services or treatment that are received without charge or legal obligation to pay.

15. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee.

16. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
17. Any services of a Physician or Nurse who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.
18. Services received after the Covered Person’s Coverage ends, except as specifically provided under the Extension of Benefits provision.
19. Services of a private duty Nurse.
20. Under the Prescription Drug Benefit, any drug or medicine:
   - Obtainable Over the Counter (OTC), except as provided under Preventive care services;
   - or the treatment of alopecia (hair loss) or hirsutism (hair removal);
   - for the purpose of weight control;
   - anabolic steroids used for body building;
   - sexual enhancement drugs;
   - cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in this Policy;
   - refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
   - for an amount that exceeds a 30 day supply
   - drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
   - purchased after Coverage under the Policy terminates;
   - consumed or administered at the place where it is dispensed;
   - if the FDA determines that the drug is:
     o contraindicated for the treatment of the Condition for which the drug was prescribed;
     o or Experimental for any reason.
21. Vitamins, minerals, food supplements, except as prescribed.
22. Vocational recreation, art, dance, poetry, music, or other similar-type therapies, including regression therapy; personal enhancement or self-actualization therapy.
23. Services for the treatment of any Injury or Sickness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot (a noisy, violent public disorder caused by a group or crowd of persons) or fighting, except in self-defense. Injury or Sickness for which Benefits are paid or payable under any workers’ compensation or occupation disease law or act, or similar legislation except for a Covered Person who is: (1) A sole proprietor or business partner who is not covered by the provisions of chapter 568 or who accepts the provisions of chapter 568 pursuant to subdivision (10) of section 31-275; or (2) an employee of a corporation and who is a corporate officer, regardless of any election by such individual to be excluded from coverage under chapter 568 pursuant to subparagraph (B)(v) of subdivision (9) of section 31-275.
24. War or any act of war, declared or undeclared; or while in the armed forces of any country.
25. Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations.
26. Obesity treatment: Services and associated expenses for the treatment of obesity, except nutrition counseling specifically provided in the Policy, and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:
   - Gastric or intestinal bypasses;
   - Gastric balloons;
   - Stomach stapling;
   - Wiring of the jaw;
   - Panniculectomy;
   - Appetite suppressants;
   - Surgery for removal of excess skin or fat.
27. Acupuncture and acupressure, aroma therapy, hypnosis, rolfing, and Hyperhidrosis.
28. Voluntary, elective or prophylactic treatment (medical, surgical or pharmacological) for a condition that is not presently exhibiting symptoms, or is in absence of a disease state or condition that is presently creating pathological changes to any body structure or function.

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**DEFINITIONS**

The terms listed below, if used, have the meaning stated.

**Accidental Injury**: A specific unforeseen event, which directly, and from no other cause, results in an Injury.

**Coinsurance**: The percentage of the expense for which the Company is responsible for a Covered Service. The Coinsurance is separate and not a part of the Deductible and Copayment.

**Copayment**: A specified dollar amount a Covered Person must pay for specified Covered Charges.

**Covered Charge(s) or Covered Expense**: As used herein means those charges for any treatment, services or supplies:
   - for Preferred Providers, not in excess of the Preferred Allowance;
   - for Out-of-Network Providers not in excess of the Reasonable and Customary expense;
   - not in excess of the charges that would have been made in the absence of this insurance;
   - not otherwise excluded under this Policy; and
   - incurred while this Policy is in force as to the Covered Person.
Covered Person: A person:
- who is eligible for Coverage as the Insured or as a Dependent;
- who has been accepted for Coverage or has been automatically added;
- for whom the required Premium has been paid; and
- whose Coverage has become effective and has not terminated.

Deductible: The amount of expenses for Covered Services and supplies which must be incurred by the Covered Person before specified Benefits become payable.

Dependent: A person who is the Insured’s:
- Legally married spouse, who is not legally separated from the Insured and resides with the Insured.
- Civil Union Partner.
- Child who is under the age of twenty-six (26) or becomes covered under a group health plan through the dependent’s own employment.

The term child refers to the Insured’s:
- Natural child;
- Stepchild; A stepchild is a Dependent on the date the Insured marries the child’s parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- Foster child is a Dependent from the moment of placement with the Insured as certified by the agency making the placement.

Elective Treatment: Those services that do not fall under the definition of Essential Health Benefits. Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person’s Effective Date of Coverage.

Emergency: An Illness, Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid severe harm.

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of Covered Services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws.

Injury: Bodily Injury due to a sudden, unforeseeable, external event which results independently of disease, bodily infirmity or any other causes.

In-Network Benefit: The level of payment made by Us for Covered Services received by a Preferred Provider under the terms of the Policy. Payment is based on the Preferred Allowance unless otherwise indicated.

Insured Percent: That part of the Covered Charge that is payable by the Company after the Deductible and/or Copayment has been paid.

Medically Necessary/Medical Necessity: We reserve the right to review claims and establish standards and criteria to determine if a Covered Service is Medically Necessary and/or Medically Appropriate. Benefits will be denied by Us for Covered Services that are not Medically Necessary and/or Medically Appropriate. In the event of such a denial, You will be liable for the entire amount billed by that Provider. You do have the right to appeal any adverse decision as outlined in the Appeals and Complaint Section of this Policy.

Covered Services are Medically Necessary if they are health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's Illness, Injury or disease; and
3. Not primarily for the convenience of the patient, Physician or other health care Provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

A Covered Service is Medically Appropriate if it is rendered in the most cost-effective manner and type of setting appropriate for the care and treatment of the Condition.

When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a Condition cannot be safely provided on an Outpatient basis.

Out-of-Network Benefit Level: The lowest level of payment made by Us for Covered Services under the terms of the Policy.[Payment is based on Reasonable and Customary charges unless otherwise indicated.

Out-of-Network Provider: Physicians, Hospitals and other Providers who have not agreed to any pre-arranged fee schedules. See the definition of Out-of-Network Benefit Level.

Out-of-Pocket: means the most You will pay during a Policy Year before your coverage pays at 100%. This includes deductibles, copayments (medical and prescription) and any coinsurance paid by You. This does not include non-covered medical expenses and elective services.

Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:
Sickness (Sick): means illness, disease or condition, including pregnancy and Complications of Pregnancy that impairs a Covered Person’s normal functioning of mind or body and which is not the direct result of an Injury or Accident. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

We, Our and Us: Nationwide Life Insurance Company.

You and Your: The Covered Person or Eligible Person as applicable.

Male pronouns whenever used include female pronouns.

ACCIDENTAL DEATH AND [DISMEMBERMENT]

If the Eligible Person, within ninety (90) days from the date of an Accident which occurs while Coverage is in force dies as the result of an Injury from such Accident, We will pay the Eligible Person’s beneficiary the amount for loss of life as shown in the Schedule of Benefits. If the Eligible Person, within ninety (90) days from the date of an Accident, which occurs while Coverage is in force, suffers dismemberment as the result of Injury from such Accident, We will pay the Eligible Person the amount set opposite such loss, as shown on the Schedule of Benefits. If more than one (1) such loss is sustained as the result of one (1) Accident, We will pay only one (1) amount, the largest to which the Eligible Person or his or her beneficiary would be entitled.

The following table shows the amounts We will pay for loss of:

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$10,000</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>$5,000</td>
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<td>$2,500</td>
</tr>
</tbody>
</table>

Loss of hand or foot means loss by severance at or above the wrist or ankle joint.

This Benefit is subject to all the terms, Conditions and exclusions of the Policy.

MEDICAL EVACUATION BENEFIT

If the Covered Person cannot continue his academic program because he sustains an Accidental Injury or Emergency Sickness while Insured under the Policy or if a Covered Dependent sustains an Accidental Injury or Emergency Sickness and is more than a 100 mile radius from his current place of primary residence or outside of his Home Country, We will pay for the actual charges Incurred for an emergency medical evacuation of the Covered Person to or back to the Covered Person’s home state, country, or country of regular domicile, up to the benefit amount shown in the Schedule of Benefits. No payment will be made under this provision unless the evacuation follows a Hospital Confinement of at least five (5) consecutive days. Before We make any payment, We require written certification by the Attending Physician that the evacuation is necessary. Any expense for medical evacuation requires Our prior approval and coordination. For international students, once evacuation is made outside the country, Coverage terminates. This Benefit does not include the transportation expense of anyone accompanying the Covered Person or visitation expenses.
REPATRIATION OF REMAINS BENEFIT
If the Covered Person dies while Insured under the Policy and is more than 100 miles from his permanent residence or outside of his Home Country, We will pay for the actual charges incurred for embalming, and/or cremation and returning the body to his place of permanent residence in his home state, country or country of regular domicile, up to the benefit amount shown in the Schedule of Benefits. Expenses for repatriation of remains require the Policyholder’s and Our prior approval. If You are a United States citizen, Your Home Country is the United States. This Benefit does not include the transportation expense of anyone accompanying the body, visitation or lodging expenses or funeral expenses.

FAMILY TRAVEL BENEFIT
If the Insured is Hospital Confined due to an Accidental Injury or Emergency Sickness for more than 5 consecutive days, is likely to be hospitalized for more than 5 days or is in critical condition, We will pay for expenses reasonably Incurred:

1. to bring one person designated by the Insured to and from the Hospital or other medical facility where the Insured is Confined if the Insured is alone and if the place of Confinement is outside a 100 mile radius from the Insured’s primary place of residence. Expenses will be limited to the actual cost with no cost sharing for one economy round-trip airfare ticket to and the hotel accommodations in the place of the Hospital Confinement. Payment for meals, ground transportation and other incidentals are the responsibility of the Family Member or friend. With respect to any one (1) trip, this benefit is payable only once for that trip, regardless of the number of Covered Persons on that trip. No benefits are payable unless the trip is approved in advance by the Administrator.

2. To return to their current place of primary residence, with an attendant if necessary, any of the Insured’s Children who were accompanying the Insured when the Injury or Emergency Sickness occurred.

CLAIM PROCEDURES
In the event of Injury or Sickness, students should:

1. Report to their Physician, Hospital or Student Health Center.

2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.

3. File claim within ninety (90) days of Injury or first treatment for a Sickness. Bills should be received by the Company within ninety (90) days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

SUBMIT ALL MEDICAL CLAIMS TO:
Cigna
PO Box 188061
Chattanooga, TN 37422-8061
Electronic Payor ID: 62308

Direct all questions regarding benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Consolidated Health Plans.

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540 or Toll Free (800) 633-7867
www.chpstudent.com
Group Number: S200595

Servicing Broker:
Bailey Agencies, Inc.
15 Thames Street, Suite 100
Groton, CT 06385
Telephone (860) 326-3085
Email: www.baileyagencies.com

CLAIMS APPEAL PROCESS
Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person must request an appeal in writing within 180 days of the date appearing on the EOB. The appeal request must include any additional information to support the request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator at the address below.

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
www.chpstudent.com
(413) 733-4540 or 800-633-7867
VALUE ADDED SERVICES

VISION DISCOUNT PROGRAM
For Vision Discount Benefits please go to:
www.chpstudent.com

NURSE HOTLINE FOR STUDENTS
For quick, sound medical advice from specially trained Nurses
24 hours a day, 365 days per year
Call toll free at 800-557-0309

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE
FrontierMEDEX ACCESS services is a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence. FrontierMEDEX is your key to travel security.
For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867.
If you have a medical, security, or travel problem, simply call FrontierMEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 1-800-527-0218 or if you are in a foreign country, call collect at: 1-410-453-6330.
If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center. FrontierMEDEX will then take the appropriate action to assist You and monitor Your care until the situation is resolved.