Student Health Insurance
Designed for the Students of
Western Washington University
(Graduate Students)
2016-2017

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH

Policy Number: 302-010-4614
Effective: 09/01/2016 to 08/31/2017
Group Number: S212514

IMPORTANT DISCLOSURE:
To find out whether the care you need is covered, please call Consolidated Health Plans at 1-800-633-7867 or email us at customerservice@consolidatedhealthplan.com.

At all times you are covered under this policy, all of the benefits to which you are entitled will be provided according to Washington and Federal law, even if this version of your policy form says something different.

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.

NONDISCRIMINATORY
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.

Administered by:

CHP Student

Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

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WHERE TO FIND HELP

For questions about claims status, eligibility, enrollment and benefits please contact:

For Questions About:	Please Contact:
Enrollment Dependent Enrollment	**Wells Fargo Student Insurance** **(800) 853-5899** studentinsurance@wellsfargo.com
Insurance Benefits Preferred Provider Listings Claims Processing	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 www.chpstudent.com
Preferred Provider Listings	**Cigna PPO** **www.cigna.com**
Prescription Drug Benefit & Providers	**Cigna PPO** **www.cigna.com**

AM I ELIGIBLE?

The Western Washington University 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.

To be eligible for this Insurance Program:

- Graduate Students taking three (3) credit hours or more or one (1) credit Thesis are eligible to enroll in this insurance plan.

The following courses are excluded from being applied towards the required minimum credit hours: Distance learning or internet courses, Courses taken as audit, Courses taken as Pass/Non-Pass, Courses taken Grad Non-Degree, Home Study Correspondence, TV courses.

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 and dependent children under age twenty-six (26). Dependent Eligibility expires concurrently with that of the Insured Student.

Students may also enroll their Dependents within sixty (60) days of an eligible qualifying event. Eligible qualifying events for a Dependent are defined in the Master Policy. Enrollment requests (including payments) received after the sixty (60) 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

The Western Washington University Student Health Insurance Plan provides coverage to Graduate students for a twelve (12) month period - from 12:01 a.m. **September 1, 2016**, **through August 31, 2017.**

Please contact Consolidated Health Plans at 1-800-633-7867 or email us at customerservice@consolidatedhealthplan.com for information regarding the cost of this plan.

TERMINATION

Coverage will terminate at 11:59 p.m. standard time at the Policyholder's address on the earliest of:

- The Termination Date of the Policy;
- The date the Insured ceases to an Eligible Person (see Premium refund section for details);
- The last day of the term of Coverage for which Premium is paid;
- The date the Covered Person departs the Policyholder's school for their Home Country. No Benefits will be payable for any medical treatment received in the Covered Person's Home Country.
- The date a Covered Person enters full time active military service. Upon written request within ninety (90) days of leaving school, We will refund the unearned pro-rata Premium to such person upon written request.
- 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 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.

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.

This Extension of Benefits provision is applicable only to the extent the Covered Person will not be covered under this or any other similar health insurance policy in the ensuing term of Coverage.

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

PREMIUM REFUND POLICY

You are eligible for Coverage if You meet the definition of Eligible Person as determined by the Policyholder and Us.

Any Insured withdrawing from school must submit documentation or certification of the medical withdrawal to Us at least thirty (30) days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or thirty (30) days after the start date of the medical leave of absence from school, any Insured voluntarily withdrawing from school during the first thirty-one (31) days of the period for which Coverage is purchased, will not be covered under this Policy and a full refund of Premium will be made minus the cost of any claim Benefits made by Us. Insureds withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed except as otherwise specified herein.

We maintain the right to investigate eligibility status and attendance records to verify that the Policy eligibility requirements have been met. If We discover that the Policy eligibility requirements have not been met, Our only obligation is refund of Premium less any claims paid.

Eligibility requirements must be met each time Premium is paid to renew Coverage.

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.

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 or surgery, the call must be made at least five (5) working days prior to Hospital Confinement or surgery. In the case of an Emergency, the call should take place within two (2) working days of admission or as soon as reasonably possible.

Pre-Certification is not required for Medical Emergency or Hospital Confinement for maternity care.

Pre-Certification is not required for a Covered Person receiving mental health care and treatment rendered by a state hospital if the Covered Person is involuntarily committed to a state hospital.

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;
- All Inpatient maternity care after the initial 48/96 hours;
- All partial hospitalization in a Hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse;
- Surgery.

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. In no event will the review period extend beyond twenty (20) working days with regard to Experimental or Investigational treatments except with the informed, written consent of the Covered Person. 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.
- The specific time period within which the Review Organization will reconsider its decision.

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.

PRE-ADMISSION NOTIFICATION

Pre-Notification of Medical Non-Emergency Hospitalizations:
The Covered Person, Physician or Health Care Facility must call the toll free telephone number on the back of the Identification Card at least five (5) working days prior to the planned admission.

Notification of Medical Emergency Admissions:
The Covered Person, Physician, Covered Person's representative, or Health Care Facility should call the toll free telephone number on the back of the ID card within two (2) working days of the admission to provide notification of any admission due to Medical Emergency.

Important: Failure to follow the notification procedure will not affect Benefits otherwise payable under the Policy. Pre-notification is not a guarantee that Benefits will be paid.

MANDATED BENEFITS

Benefits subject to applicable Deductible, Coinsurance, and Copayments as outlined in the Schedule of Benefits. Note: Wellness/Preventive Benefits under the Affordable Care Act (ACA) are required to meet federal regulations; no cost sharing will apply to these benefits for In-Network services. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate.

Anesthesia for Dental Services
Coverage is provided for general anesthesia services and related facility charges in conjunction with any dental procedure performed in a Hospital or Ambulatory Surgical Center if such anesthesia services and related facility charges are Medically Necessary because the Covered Person:

(a) Is under the age of seven (7), or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

(b) Has a medical condition that the Covered Person's Physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Covered Person's Physician.

"General anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

Chemical Dependency
Coverage is provided for treatment of chemical dependency in an approved treatment facility program.
"Chemical Dependency" means an Illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or

psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

"Approved treatment program" means a discrete program of chemical dependency treatment provided by a treatment program certified by the department of social and health services.

Colorectal Cancer Screening

Coverage is provided for colorectal cancer examinations and laboratory tests consistent with the recommendation of the U.S. preventive services task force or the federal centers for disease control and prevention. Benefits include:

(a) For any of the colorectal screening examinations and tests in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the patient's Physician after consultation with the patient; and

(b) To a covered individual who is:

- At least fifty (50) years old; or
- Less than fifty (50) years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.

Congenital Anomalies in Children and Newborns

Coverage is provided for newborn infant children from and after the moment of birth, subject to eligibility. Coverage provided includes, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

Contraceptive Coverage

Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other Outpatient services.

Diabetes

Coverage is provided for the following services and supplies for Covered Persons with diabetes:

- Coverage for pharmacy services, appropriate and Medically Necessary equipment and supplies, as prescribed by a health care Provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and
- Outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care Provider. Diabetes outpatient self-management training and education may be provided only by health care Providers with expertise in diabetes.

Home Health Care and Hospice Care

Coverage is provided for supplies and services required by a Home Health and/or Hospice agency to perform services. Outpatient DME is paid the same as Inpatient DME.

Coverage is provided for Hospice care coverage for terminally ill patients for an initial period of care of not less than six (6) months and may provide benefits for an additional six (6) months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the Attending Physician.

Coverage is provided for Home Health Care benefits for at least a minimum of one hundred thirty (130) health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one (1) visit.

In lieu of hospitalization or other institutional care benefits are available for home health care at an equal or lesser cost. The care must be recommended by the Insured's Physician and agreed to by the Insured. Prior approval is required and may be obtained by contacting the plan administrator listed in the brochure and on the ID card.

Maternity & Newborn Coverage

Including, but not limited too:

a) In utero treatment for the fetus;
b) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;
c) Nursery services and supplies for newborns, including newly adopted children;
d) Infertility diagnosis;
e) Prenatal and postnatal care and services, including screening;
f) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia.

Services provided:

a) For dependent daughters on the same basis that the coverage is included for other Insured;
b) Newborns delivered of dependent daughters to the same extent, and on the same basis, as newborns delivered to the other Insured.
c) The base-benchmark plan's limitations on services in this category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.
d) Include diagnosis of pregnancy, prenatal care, delivery, and care for complications of pregnancy, Physician services, and hospital services;
e) Newborn coverage that is not less than the coverage for the child's mother, for no less than three (3) weeks, even if there are separate hospital admissions; and

Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if Medically Necessary

Mammography
Coverage is provided for the screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's Physician or advanced registered nurse practitioner or physician assistant.

Mental Health Treatment/Substance Abuse Disorders
Coverage is provided for Mental Health Treatment categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (including Mental Health, substance abuse disorders and behavioral health treatment) on the same basis as any other Condition.

Coverage includes but is not limited to:

(i) Inpatient, Residential and Outpatient services, including partial hospital programs or inpatient services;
(ii) Chemical dependency detoxification;
(iii) Behavioral treatment or neurodevelopmental therapy for a DSM category diagnosis;
(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a Skilled Nursing Facility;
(v) Prescription medication prescribed during an Inpatient and Residential course of treatment;
(vi) Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency.
(vii) Services and treatment must be delivered in a home health setting on parity with medical surgical benefits, consistent with state and federal law.

(viii)Treatment for eating disorders; and

(vix) If a Covered Person (or Covered Person's Dependent) is involuntarily committed to a state hospital as defined by RCW 72.23.010, any required preauthorization requirement will be waived.

Services not covered:

(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;
(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the DSM-IV, or for "V code" diagnoses except for Medically Necessary services for neurodevelopmental therapy or for parent-child relational problems for children five (5) years of age or younger, neglect or abuse of a child for children five (5) years of age or younger, and bereavement for children five (5) years of age or younger, unless this exclusion is preempted by federal law;
(iii) Not Medically Necessary court-ordered mental health treatment.

Phenylketonuria Treatment
Coverage is provided for the formulas necessary for the treatment of phenylketonuria.

Prenatal Testing for Congenital Disorders
Coverage is provided for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy to such enrollees when those services are determined to be Medically Necessary by the disability contractor in accord with standards set in rule by the board of health.

Prostate Cancer Screening
Coverage provided for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's Physician, advanced registered nurse practitioner, or Physician assistant.

Reconstructive Breast Surgery
Coverage is provided for reconstructive breast surgery resulting from a mastectomy which resulted from disease, Illness, or Injury. Including but not limited to:

- All stages of one (1) reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.
- Mastectomy bras; The Covered Person must be given reasonable access to a number of bras including replacement due to usage;
- For prostheses and physical complications including lymphedemas;
- Coverage may not be denied because of a mastectomy or lumpectomy performed on the Covered Person more than five (5) years previously.

Self-administered Anticancer Medications
Coverage is provided for prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis at least comparable to cancer chemotherapy medications administered by an approved health care Provider or facility.

Temporomandibular Joint Disorder
Coverage is provided for medical services related to the treatment of temporomandibular joint disorders (TMJ).

DEFINITIONS

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

Accident: An event that is sudden, unexpected, and unintended, and over which the Covered Person has no control.

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

Ambulatory Surgical Center: A facility which meets licensing and other legal requirements and which:

- Is equipped and operated to provide medical care and treatment by a Physician;
- Does not provide services or accommodations for overnight stays;
- Has a medical staff that is supervised full time by a Physician;
- Has full-time services of a licensed Registered Nurse (R.N.) at all times when patients are in the facility;
- Has at least one operating room and one recovery room and is equipped to support any surgery performed;
- Has x-ray and laboratory diagnostic facilities;
- Maintains a medical record for each patient; and
- Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

Anesthetist: A Physician duly licensed according to state law, who administers the anesthesia agent during a surgical procedure.

Assistant Surgeon: A Physician who assists the Surgeon who actually performs a surgical procedure.

Attending Physician: A Physician who is charged with the overall care of the patient and who is responsible for directing the treatment program.

Benefit(s): The extent of those services listed in the Covered Charges.

Brand Name Prescription Drugs: Drugs for which the drug manufacturer's trademark registration is still valid, and who's trademarked or proprietary name of the drug still appears on the package label.

Chronic and Seriously Debilitating: Diseases or Conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

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

Company: Nationwide Life Insurance Company. Also hereinafter referred to as We, Our and Us.

Complications of Pregnancy: A Condition which:

- When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed

- abortion; (e) preeclampsia/eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; (i) and other similar medical and surgical Conditions of comparable severity related to pregnancy; or
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will **not** include:

- false labor;
- occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- morning sickness; and
- similar Conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Condition: Sickness, ailment, Injury, or pregnancy of a Covered Person.

Confinement/Confined: An uninterrupted stay following admission to a Health Care Facility. The re-admission to a Health Care Facility for the same or related Condition, within a 72 hour period, will be considered a continuation of the Confinement. Confined/Confinement does **not** include observation, which is a review or assessment of eighteen (18) hours or less, of a person's Condition that does not result in admission to a Hospital or Health Care Facility.

Copayment: A specified dollar amount a Covered Person must pay for specified Covered Charges. The Copayment is separate from and not a part of the Deductible or Coinsurance.

Coverage: The right of the Covered Person to receive Benefits subject to the terms, conditions, limitations and exclusions of the Policy.

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; and
- Not in excess of the charges that would have been made in the absence of this insurance; and
- 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;
- for whom the required Premium has been paid; and
- whose Coverage has become effective and has not terminated.

Covered Services: Means the services and supplies, procedures and treatment described herein, subject to the terms, conditions, limitations, and exclusions of the Policy.

Custodial Care: Care that is primarily for the purpose of meeting non-medical personal needs, such as help with the activities of daily living and taking medications. Activities of daily living include, but are not limited to, bathing, dressing or grooming, eating, toileting, walking, and getting in and out of bed. Custodial Care can usually be provided by someone without professional medical skills or training.

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

Dermatology: The diagnosis and treatment of skin disorders. Covered expenses do not include cosmetic treatment and procedures.

Durable Medical Equipment: A device which:

- Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
- Is used exclusively by the patient;

- Is routinely used in a Hospital but can be used effectively in a non-medical facility;
- Can be expected to make a meaningful contribution to treating the patient's Sickness or Injury; and
- Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.

Durable Medical Equipment does not include: 1) comfort and convenience items; 2) equipment that can be used by Family Members other than the patient; 3) health exercise equipment; and 4) equipment that may increase the value of the patient's residence. Such items that do not qualify as Durable Medical Equipment include, but are not limited to: modifications to the patient's residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

Effective Date: The date Coverage becomes effective at 12:01 a.m. on this date.

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. Elective Benefits is shown on the Schedule of Benefits, as applicable.

Eligible Class(es): A group of people who are eligible for Coverage under the Policy as defined by the Policyholder and Us, and as listed in the Schedule of Benefits.

Eligible Person: The person who belongs to an Eligible Class as described in the Schedule of Benefits.

Emergency Medical Condition: means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

Emergency Medical Transportation Services: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide ground and air transportation to a Hospital for Emergency care or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care, if a Physician specifies in writing that such transport is Medically Necessary. Charges are payable only for transportation from the site of an Emergency to the nearest available Hospital that is equipped to treat the Condition.

Emergency Services: means a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

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).

Evaluation and Management: Professional services provided by a Physician in the Physician's office or in an out patient or other ambulatory facility.

Expense Incurred: The charge made for a service, supply, or treatment that is a Covered Service under the Policy. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.

Experimental/Investigational: The service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. In determining whether services are experimental or investigational, we will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient. For further explanation, see of Medically Necessary/Medical Necessity provision.

Family Member: A person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.

Formulary: A list of Brand Name Drugs that are available at a lower cost than Non-Formulary Brand Drugs.

Formulary Brand Drug: A Brand Name drug that is on the Formulary.

Generic Drugs: A non-brand name drug, which is a pharmaceutical equivalent to a Brand Name Prescription Drug, sold at a lower cost.

Habilitative Treatment or Therapy: Treatment or therapy that develops or attempts to develop a function that did not previously exist, but would normally be expected to exist. Treatment or therapy is considered habilitative if the function has achieved maximal or optimal improvement or is static, showing no progressive improvement with additional treatment.

Health Care Facility: A Hospital, Skilled Nursing Facility, Sub-Acute Facility, or other duly licensed, certified and approved health care institution which provides care and treatment for sick or injured persons.

Home Country: The Insured's country of regular domicile.

Home Health Care: Services and supplies that are Medically Necessary for the care and treatment of a covered Illness (including Mental Illness or Substance Abuse Disorder) or Accidental Injury and are furnished to a Covered Person at the Covered Person's residence.

Home Health Care consists of, but shall not be limited to, the following:

- Physician-directed Home Health Care follow-up visits provided to a mother or newborn child within seventy-two (72) hours after the mother's or newborn child's early discharge from an Inpatient stay. The Provider conducting the visit must have knowledge and experience in maternity and newborn care.
- Care provided in a Covered Person's home by a licensed, accredited Home Health Care agency. This care must be under the direction of a Physician and in conjunction with the need for Skilled Nursing Care and includes, but is not limited to:
    - Skilled nursing (L.P.N., R.N.) part-time or intermittent care;
    - medical social services;
    - Infusion services;
    - Dialysis services
    - Part-time or intermittent certified nurse assistant services or home health aide services, which provide support in the home under the supervision of an R.N. or a physical, speech or occupational therapist. A visit of four (4) hours or less by a certified nurse assistant or home health aide will count as one (1) Home Health Care visit. Each visit by any other home health agency representative will count as one (1) Home Health Care visit;
    - Physical Therapy;
    - occupational therapy;
    - Speech Therapy.

Hospice: A coordinated plan of home and Inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with physical, psychological, spiritual, social, and economic stresses.

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. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center, and a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically required for treatment of physical disability.

Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include an institution, or part thereof, which is, other than incidentally, a place for rest, the aged, a place for educational or Custodial Care or Hospice.

Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least eighteen (18) hours or greater for which a room and board charge is made by reason of Sickness or Injury for which Benefits are payable. The readmission for the same or related Sickness or Injury, within a seventy-two (72) hour period, will be considered a continuation of Confinement. See Confined/Confinement.

Identification Card: Your Identification Card identifies You as a Covered Person.

Illness: Sickness or disease.

Infusion Services: Services provided in an office or Outpatient facility, or by a licensed Infusion or health care agency, including the professional fee and related supplies.

Injectable Drugs: Means a prescription drugs when an oral alternative drug is not available.

Injection Services: Services provided in an office or Outpatient facility, including the professional fee and related supplies. Injection Services does not include self-administered Injectable Drugs.

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

All injuries sustained in any one (1) Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

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.

Inpatient/Inpatient Admission: A Confinement of eighteen (18) hours or greater. See Confined/Confinement.

Insured: The Covered Person who is enrolled at and meets the eligibility requirements of the Policyholder's school.

Insured Percent: That part of the Covered Charge that is payable by the Company after the Deductible and/or Copayment has been paid, and subject to the Policy Year Maximum or Maximum Benefit, as applicable.

Lifestyle Change: A change in Your or Your Dependent's status due to marriage, divorce, dissolution of Domestic/Civil Union Partnership, age, birth, death, adoption, change in Spouse's or Domestic/Civil Union Partner's employment or health insurance or health plan Coverage, eligibility for Medicare, change in student status or any other event which impacts eligibility for Coverage under the Policy.

Life-Threatening Condition: Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted; or with potentially fatal outcomes, where the end point of clinical intervention is survival.

Maximum Benefit: The maximum payment We will make under the Policy for each Covered Person for Covered Services. This amount is shown on the Schedule of Benefits, as applicable.

Medical Literature:

- Two (2) (articles from major peer-reviewed professional medical journals which have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the Condition for which it has been prescribed; and
- No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the Condition for which it has been prescribed; and
- Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services pursuant to federal law, as accepted peer-reviewed Medical Literature.

Medically Necessary/Medical Necessity: Refer to the Medical Necessity provision of this Policy.

Non-Preferred Brand Drug: A Brand Name Prescription Drug that is on the Formulary and is available at a higher cost than Preferred Brand Drugs.

Nurse: A licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who: (a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and (b) provides medical services which are within the scope of the nurse's license or certificate who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.

Orthopedic Appliance: A supportive device or appliance used to treat a Sickness or Injury (e.g., a crutch, cane, splint, brace, supportive bandage, etc.).

Orthotic Device: A mechanical device, such as braces (but not dental) or shoes, that:

1. Is directly related to the treatment of an Injury or Sickness of the foot; and
2. Is prescribed by the Insured Person's Physician who documents the necessity for the item.

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 Maximum: The most You pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. This limit will never include Premium, balance-billed charges or health care Your Policy does not cover. Your Out-of-Network payments or other non-covered expenses and Elective Treatment do not count toward this limit.

Participating provider and participating facility: a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to Covered Persons with an expectation of receiving payment, other than Coinsurance, Copayments, or Deductibles, from the health carrier rather than from the Covered Person.

Outpatient: Not Confined in a Hospital, Skilled Nursing facility or Hospice as a registered bed patient.

Physical Therapy: Any form of the following:

- Physical or mechanical therapy;
- Diathermy;
- Ultra-sonic therapy;
- Heat treatment in any form; or
- Manipulation or massage.

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:

1. the Insured Person;
2. a Family Member of the Insured Person; or
3. a person employed or retained by the Policyholder.

Policy: The agreement between Us and the Policyholder which states the terms, conditions, limitations and exclusions regarding Coverage.

Policy Year (or plan year): The period of twelve (12) months following the Policy's Effective Date.

Policy Year Maximum: The maximum amount of Benefits we will pay for all Conditions under this Policy each Policy Year for each Covered Person. This amount is shown on the Schedule of Benefits.

Policyholder: The entity shown as the Policyholder on the Policy face page.

Pre-admission Testing: Tests done in conjunction with and within three (3) days of a scheduled surgery where a operating room has been reserved before the tests are done.

Preferred Allowance (PA): The amount a Preferred Provider has agreed to accept as payment in full for Covered Charges.

Preferred Brand Drug: A Brand Name Prescription Drug that is on the Formulary and is available at a lower cost than Non-Preferred Brand or Specialty Drugs.

Preferred Providers: Physicians, Hospitals and other healthcare Providers who have contracted to provide specific medical care at negotiated prices. See the definition of In-Network Benefit.

Preferred Provider Organization or PPO: The entity named in the Schedule of Benefits.

Premium: The amount required to maintain Coverage for each Covered Person in accordance with the terms of this Policy.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and is:

1. approved for general use by the U.S. Food and Drug Administration (FDA); and
2. prescribed by a licensed Physician for the treatment of a Life-Threatening Condition, or prescribed by a licensed Physician for the treatment of a Chronic and Seriously Debilitating Condition, the drug is Medically Necessary to treat that Condition, and the drug is on the Formulary, if any; and
3. includes "off-label" drugs (the use of a drug which is other than that stated in its FDA approved labeling; and
4. the drug has been recognized for treatment of that Condition by one of the Standard Medical Reference Compendia or in the Medical Literature as recommended by current American Medical Association (AMA) policies, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Condition.

The Drugs must be dispensed by a licensed pharmacy Provider for out of Hospital use, except as specifically provided under Preventive Care. Prescription Drug Coverage shall also include Medically Necessary supplies associated with the administration of the drug.

Preventive Care: Provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations, as specified in the Schedule of Benefits. Well Baby and Child Care, and Well Adult Care benefits will be considered based on the following:

(a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

(b) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(d) With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(e) Chronic disease management services, which include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple Providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools.

(f) Weight management services for adults and children 6 years of age and above with a BMI of 30 Kg/m2 or higher in accordance with the USPSTF A&B recommendations. Examples of the covered services are as follows:
- Group and individual sessions of high intensity (12 to 26 sessions in a year),
- Behavioral management activities, such as weight-loss goals,
- Improving diet or nutrition and increasing physical activity,
- Addressing barriers to change,
- Self-monitoring, and
- Strategizing how to maintain lifestyle changes.

Provider: A Physician, dentist, denturist, Health Care Facility, or Urgent Care Facility that is licensed or certified to provide medical services or supplies.

Reasonable and Customary (R&C): The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the Provider;
- The negotiated rate, if any; or
- The fee often charged for in the geographical area where the service was performed.

The Reasonable Charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 80th percentile of Fair Health Inc. schedules. The Insured Person may be responsible for the difference between the Reasonable Charge and the actual charge from the Provider.

For a Provider who has a reimbursement agreement, the Reasonable Charge is equal to the Preferred Allowance under any reimbursement agreement with Us, either directly or indirectly through a third party, as described in the Preferred Provider Benefit provision. If a Provider accepts as full payment an amount less than the rate negotiated under the reimbursement agreement, the lesser amount will be the maximum Reasonable Charge.

Reconstructive Surgery: Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, disease, or Accidental Injury to either: (1) improve function or (2) create a normal appearance.

Rehabilitative: The process of restoring a person's ability to live and work after a disabling Condition by:

- Helping the person achieve the maximum possible physical and psychological fitness;
- Helping the person regain the ability to care for himself or herself;
- Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance and with psychological readjustment.

Reservist: A member of a reserve component of the Armed Forces of the United States. Reservist also includes a member of the State National Guard and the State Air National Guard.

Restorative Speech Therapy: Therapy after an Injury, including stroke, and treatment of a speech abnormality resulting from surgery or trauma to anatomical structures affecting speech.

Second Opinion: Access is provided for any Covered Person for a Second Opinion, regarding any medical diagnosis or treatment plan from a qualified Preferred Provider of the Covered Person's choice

Sickness: 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.

Skilled Nursing Care: Services that are certified as Medically Necessary by a Physician and are not intermediate, domiciliary, custodial or retirement care.

Skilled Nursing Facility: A place (including a separate part of a Hospital) which:

- Regularly provides room and board for person(s) recovering from Illness or Accidental Injury;
- Provides continuous twenty-four (24) hour nursing care by or under the supervision of a Registered Nurse;
- Is under the supervision of a duly licensed Physician;
- Maintains a daily clinical record for each patient;
- Is not, other than incidentally, a place for rest, the aged, place of treatment for Alcoholism or drug and/or substance abuse or addiction; and
- Is operated pursuant to law.

Sound Natural Tooth: The major portion of the individual natural tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Specialty Drugs: Means a Prescription Drug including Injectable Drugs, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis, and which are listed in the specialty care drug list.

Standard Medical Reference Compendia: The following publications:

- The "AMA Drug Evaluations", published by the American Medical Association;
- The "American Hospital Formulary Service (AHFS) Drug Information", published by the American Society of Health System Pharmacists; or
- "Drug Information for the Health Care Provider", published by the U.S. Pharmacopoeia Convention.

Sub-Acute Facility: A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of Rehabilitative and Skilled Care Nursing.

Surgeon: A Physician who actually performs surgical procedures.

Surrogate Parenting Agreement: One in which a woman agrees to become pregnant with the intent of surrendering custody of the child.

Telemedicine: The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Neither a telephone conversation nor an electronic mail message between a Physician and patient constitutes "Telemedicine".

Termination Date: The date a Covered Person's Coverage under this Policy ends. Coverage ends at 11:59 p.m. on this date.

Urgent Care: Means short-term medical care performed in an Urgent Care Facility for non-life threatening Conditions that can be mitigated or require care within forty-eight (48) hours of onset.

Urgent Care Facility: A Hospital or other licensed facility which provides diagnosis, treatment, and care of persons who need acute care under the supervision of Physicians.

Vision Screening: A screening to determine if there are underlying medical Conditions or if a refractive exam needs to be performed. Vision Screening does not include refractive exams, which are not covered as specified in the General Exclusions and Limitations.

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.

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.

COORDINATION OF BENEFITS

If the Insured Person is insured under more than one group health plan, the benefits of the plan that covers the Insured Student will be used before those of a plan that provides coverage as a dependent Insured Person. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any

auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy on file with the Policyholder.

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, prescriptions or fitting of eyeglasses or contact lenses (except as in the case of Injury or as provided); vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except when due to a disease process; except eye refractions, performed by a Physician or optometrist, when used as a diagnostic tool in conjunction with a chronic or acute medical Condition. Repair or replacement of eye glasses or contact lens except when required as a direct result of an Injury.
2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids and the fitting or repairing or replacement of hearing aids, except in the case of Accident or Injury.
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 including weak feet, fallen arches, flat foot, pronated foot, subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions (except capsular or bone surgery), any type of massage procedure on or to the foot, corrective shoes, shoe inserts and Orthotic Device; except for treatment of Injury, infection or disease or as provided herein.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that are to be furnished primarily to improve appearance rather than a physical function or control of organic disease except as provided herein 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; warts, non-malignant moles and lesions; 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); lipectomy services and supplies related to surgical suction assisted lipectomy; rhinoplasty; nasal and sinus surgery and deviated nasal septum, including submucous resection except when Medically Necessary 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 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 has a terminal Condition that , according to the Physician's current diagnosis, has a high probability of causing death within two (2) years from the date of the request for medical review.
8. Custodial Care; long-term care; Care provided in a: rest home, home for the aged, halfway house, health resort, college infirmary or any similar facility for domiciliary or Custodial Care, or that provides twenty-four (24) hour non-medical residential care or day care (except as provided for Hospice care).
9. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein).
10. 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 or if the Insured is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place. This exclusion will not apply to passengers if they are insured under the Policy.

11. Injury resulting from participation in any hazardous activity, including: travel in or upon an ATV (all terrain or similar type two or three wheeled vehicle and/or off-road four wheeled motorized vehicles; motor vehicles not primarily designed and licensed for use on public streets or highways or parachuting, hang gliding, skydiving, parasailing, scuba diving, skin diving, glider flying, sailplaning, racing or speed contests, mountaineering (where ropes or guides are customarily used), rock wall climbing, rodeo or bungee jumping; (except as specifically provided in this Policy).

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 on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.

13. Reproductive/Infertility services, including but not limited to: family planning, treatment of infertility (male or female) including medication, surgery, supplies, and fertilization procedures rendered for the purpose or with the intent of inducing conception, premarital examination; impotence, organic or otherwise; sterilization reversal; vasectomy/vasectomy reversal, except as specifically provided in this Policy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, artificial insemination, embryo transfer or similar procedures that augment or enhance Your reproductive ability.

14. Pregnancy that results under a Surrogate Parenting Agreement.

15. Hospital Confinement or any other services or treatment that are received without charge or legal obligation to pay; Inpatient Room & Board charges in connection with a Hospital stay primarily for environmental change; Inpatient room & board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an Outpatient basis.

16. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee; Services rendered by employees or Physicians or other persons or retained by the University or for the use of the Universities facilities.

17. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.

18. Expenses that would be payable or medical treatment that is available, under any governmental or national health plan for which the Covered Person could be eligible.

19. Services received before the Covered Person's Effective Date or during an Inpatient stay that began before the Insured's Effective Date; Services received after the Covered Person's Coverage ends, except as specifically provided under the Extension of Benefits provision.

20. Services of a private duty Nurse.

21. Under the Prescription Drug Benefit, any drug or medicine:
    - Obtainable Over the Counter (OTC), except as specifically provided under Preventive Care;
    - For the treatment of alopecia (hair loss) or hirsutism (hair removal);
    - For the purpose of weight control;
    - Anabolic steroids used for body building;
    - Growth hormones (unless Medically Necessary for treatment of Sickness);
    - For the treatment of infertility;
    - 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;
    - Treatment of nail (toe or finger) fungus;
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
    - For an amount that exceeds a thirty (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:
        i. contraindicated for the treatment of the Condition for which the drug was prescribed; or
        ii. Experimental for any reason.

22. Vitamins, minerals, food supplements, herbs, herbal formulas, or home remedies; except as prescribed.

23. Vocational recreation, art, dance, poetry, music, or other similar-type therapies, including regression therapy; personal enhancement or self-actualization therapy.

24. Injuries sustained as a result of or any attempt at intentional self-inflicted Injury or any attempt at intentional self-inflicted Injury.

25. 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; or fighting, except in self-defense.
26. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
27. War or any act of war, declared or undeclared; or while in the armed forces of any country.
28. 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.
29. Obesity treatment: Services and associated expenses for the treatment of obesity, except as provided under Preventive Care or 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.
30. Weight increase or reduction services, except as specifically provided under Preventive Care; general fitness, exercise programs, health club memberships and weight management programs; exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Physician's prescription.
31. received outside of the United States of America, except when Medically Necessary for an Emergency Confinement in a Hospital, except as specifically provided.
32. Non-cystic acne.
33. Acupressure, aroma therapy, hypnosis, rolfing, Hyperhidrosis, Psychosurgery & biofeedback.
34. Diagnosis and treatment of sleep disorders including but not limited to apnea monitoring, sleep studies, and oral appliances used for snoring, except treatment and appliances for documented obstructive sleep apnea.
35. Elective Treatment, except as specified in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT

If the Eligible Person, within one (1) year from the date of an Accident which occurs while Coverage is in force, dies as the result of Injury from such Accident, We will pay the Eligible Person's beneficiary the amount for loss of life as shown on the Schedule of Benefits. If the Eligible Person, within one (1) year 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:

Life..... $5,000
Both hands or both feet or the entire sight of both eyes $5,000
One hand or one foot or the entire sight of one eye..... $2,500
More than one of the above Losses due to one Accident $5,000

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, and with regard to eyes, entire or irrecoverable loss of sight. Only the largest benefit will be paid if more than one (1) loss results from any one Accident.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight must be entire and irrecoverable.

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

MEDICAL EVACUATION BENEFIT

If the Insured cannot continue his academic program because he sustains an Accidental Injury or Emergency Sickness while Insured under the Policy 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 charge Incurred for an emergency medical evacuation of the Covered Person to or back to the Insured's home state, country, or country of regular domicile. 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 charge 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.

SCHEDULE OF BENEFITS

Actuarial Value: 79.89%

Equivalent or next lowest coverage level: Gold

Please note, while this plan provides an actuarial value of at least 60% in accordance with the Patient Protection and Affordable Care Act, it may not provide an actuarial value on parity with those of the same metal tier currently offered in the health insurance marketplace in your state. The metal tier coverage level noted above indicates the actual or next lowest corresponding metal tier based on the referenced actuarial value of this plan.

Your Coverage provides for the utilization of Preferred Providers in a Preferred Provider Organization (PPO). Certain Benefits are paid at different rates if the service is not provided by a Preferred Provider. See the Definitions page for the definition of Preferred Provider Organization, Preferred Provider, Out-of-Network Provider, In-Network Benefit and Out-of Network Benefit. The Preferred Provider Organization(s) for Your Coverage is: Cigna (www.cigna.com).

Explanation of Reference Number

[1] Must be Pre-Certified/Pre-Notified

EFFECTIVE DATE: 09/01/2016 **ANNIVERSARY DATE**: 08/31/2017

PREMIUM:

	Annual
Student	$3,188
Spouse/Domestic Partner	$3,188
Per Child*	$3,188

**If more than three (3) children are to be covered as a Dependent on the plan, the rate will reflect maximum of (3) children.*

PLEASE NOTE: ALL BENEFITS ARE PER POLICY YEAR UNLESS OTHERWISE NOTED.

Covered Charges for Essential Health Benefits (Ambulatory Patient Services)	**In-Network Benefit**	**Out-of-Network Benefit**
Policy Year Maximum Benefit	Unlimited	
Deductible per Covered Person per Policy Year (except as specified herein)	$300	$300
Out of Pocket Maximum – • Includes Copayments; Deductibles & Prescription Drug Copayments; • Excludes non-covered medical expenses & Elective services; • Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year; • Once the In-Network Out-of-Pocket Limit is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network. • Once the Out-of-Network Out-of-Pocket Limit is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% Out-of-Network.	$6,600 (per Covered Person) $13,200 (Family)	$6,600 (per Covered Person) $25,400 (Family)
Insured Percent (except as specified herein)	80% of the Preferred Allowance (PA)	50% of the Reasonable and Customary Charges (R&C)

Preventive Care (See Definition for additional information. Also refer to Reproductive Services below.)		
Preventive Services	100% of PA + waiver of Deductible	50% of R&C
Outpatient Services - (other than Surgery, Maternity, Mental Health Treatment/Chemical Dependency)		
Office visits, including Evaluation and Management and diagnostic services performed and billed by a Physician's office, including Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician. Does not apply when related to surgery or Physical Therapy. Also includes treatments & associated supplies and services; Second Opinion access; therapeutic injections and related supplies.	100% of PA after a $30 Copayment per visit + waiver of Deductible	70% of R&C after a $30 Copayment per visit+ waiver of Deductible
Consulting Physician/Specialists (other than Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician); Does not apply when related to surgery or Physical Therapy.	100% of PA after a $50 Copayment per visit+ waiver of Deductible	70% of R&C after a $50 Copayment per visit+ waiver of Deductible
Diagnostic Imaging Includes x-ray services which are diagnostic or therapeutic.	80% of PA	50% of R&C
Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.	80% of PA	50% of R&C
Genetic Testing - Limited to five (5) tests per Cover Person per lifetime.	80% of PA	50% of R&C
Blood and Blood Products - Includes blood storage and blood bank services and supplies.	80% of PA	50% of R&C
CT Scan, CAT, MRI, and /or PET Scans	80% of PA	50% of R&C
Infusions (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	50% of R&C
Injections (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	50% of R&C
Radiation & Chemotherapy – includes education and supplies for self administered chemotherapy	80% of PA	50% of R&C
Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - includes administration and supplies. Coverage is provided for in home and outpatient dialysis services.	80% of PA	50% of R&C
Diagnostic procedures – including but not limited to Colonoscopies, Cardiovascular testing (including Pulmonary function studies) and Neurology/Neuromuscular procedures.	80% of PA	50% of R&C
Inpatient Service (other than Surgery, Maternity, Mental Health Treatment/Chemical Dependency)		
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, dialysis, miscellaneous items used in association with a surgical event, Pre-Admission Testing and Inpatient Rehabilitation.	80% of PA	50% of R&C
Room and Board expense [1], daily semi-private room rate and general nursing care provided by the Hospital.	80% of PA	50% of R&C
Intensive Care Room [1]	80% of PA	50% of R&C
Physician visit, during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility, limited to one (1) visit per day and does not apply when related to surgery. Includes Second Opinion.	80% of PA	50% of R&C
Consulting Physician, when requested and approved by the Attending Physician.	80% of PA	50% of R&C
Inpatient Rehabilitation Facility [1] – Including professional services offered within the facility. Limited to sixty (60) days per Policy Year.	80% of PA	50% of R&C
Skilled Nursing Facility and Sub-Acute Care Facility [1] - Includes semi-private room and board, all professional services, general nursing services, meals and prescribed diets & medicines, supplies, Diagnostic Imaging, laboratory, and Rehabilitation. Maximum sixty (60) days per Policy Year.	80% of PA	50% of R&C

Surgical Services [1] (Inpatient and Outpatient)		
When multiple surgeries are performed through the same incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. When multiple surgeries are performed through one (1) or more incisions at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. The Benefit for the primary or most expensive procedure or 50% of the Benefit otherwise payable for each subsequent procedure.		
Surgeon	80% of PA	50% of R&C
Assistant Surgeon - Coverage is limited to 25% of Surgeon's payment	80% of PA	50% of R&C
Anesthetist Services - Coverage is limited to 25% of Surgeon's payment	80% of PA	50% of R&C
Inpatient Surgical Miscellaneous - Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	80% of PA	50% of R&C
Outpatient Surgical Miscellaneous **-** Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.	80% of PA	50% of R&C
Other Surgical Services [1]		
General Anesthesia for Dental services	80% of PA	50% of R&C
Reconstructive Surgery	80% of PA	50% of R&C
Organ Transplant Surgery –	80% of PA	50% of R&C
Organ Donor Services	80% of PA	Not Covered
Gender Reassignment Surgery - Coverage is provided only with a diagnosis of gender dysphoria.	80% of PA	50% of R&C
Reproductive Services		
Voluntary Sterilization Surgery **Note**: Sterilization procedures for women are covered under Preventive Care.	80% of PA	50% of R&C
Infertility Services - Includes diagnosis of infertility and the treatment of an underlying condition causing infertility. Excludes infertility treatment.	80% of PA	50% of R&C
Contraceptives, including devices and related procedures, except as provided under the Prescription Drug Benefit.	100% of PA + waiver of Deductible	50% of R&C
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.		
Pre- and Post-Natal Care – Includes delivery and Inpatient Physician visits for mother and baby.	Paid as any other Sickness	
Hospital services [1] - Includes room and board, general nursing care, meals and prescribed diets, pharmaceuticals administered while an Inpatient, anesthesia, dressings, other miscellaneous items, rooming in for maternity care, delivery, routine newborn care, including circumcision, or sick newborn care.	Paid as any other Sickness	
Diagnostic services performed and billed by a Physician's office, including ultrasounds and amniocentesis.	Paid as any other Sickness	
Mental Health Treatment/Chemical Dependency		
Inpatient services [1] - including Alcoholism/Drug detoxification.	Paid the same as any other Sickness	
Outpatient Office Visits	Paid the same as any other Sickness	
Urgent Care and Emergency Services		
Urgent Care (including provider services; facility costs and supplies)	80% of PA after a $50 Copayment per visit	50% of R&C after a $50 Copayment per visit
Emergency services – visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition**.** Includes Physician's fees, Diagnostic Imaging, Laboratory, Injections, use of Emergency Room and supplies, emergency prescription drugs and facility charges. ***Copayment waived if admitted. Out-of-Network charges will never be more than $50 over the In-network charges.***	80% of PA after a $200 Copayment per visit	80% of PA after a $200 Copayment per visit

Emergency Medical Transportation services – includes treatment provided as part of the ambulance service	80% of PA	50% of R&C
Other Services		
Allergy Services (testing/Injections/treatment) – Includes treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments. Also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.	80% of PA	50% of R&C
Clinical Trials - Includes coverage for routine patient costs associated with a Covered Person's participation in a clinical trial, including prescription drugs that are not the subject of the trial, but are prescribed as part of the trial. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care of the Covered Person.	80% of PA	50% of R&C
Habilitative care – including Physical, Speech, Occupational and Aural therapies – only when prescribed by the Attending Physician. Includes services provided in a school based setting.	100% of PA after a $25 Copayment per visit	70% of R&C after a $25 Copayment per visit
Rehabilitative care – including Physical, Speech & Occupational therapies – only when prescribed by the Attending Physician.	100% of PA after a $25 Copayment per visit	70% of R&C after a $25 Copayment per visit
Pulmonary Therapy	80% of PA	50% of R&C
Cardiac Therapy	80% of PA	50% of R&C
Neuro-Developmental Therapy	80% of PA	50% of R&C
Chiropractic care (including spinal manipulation services – up to ten (10) visits per Policy Year; Services include x-rays, office visits, laboratory services, manipulations and modalities (i.e., hot packs, cold packs and ultrasounds, etc.).	100% of PA after a $25 Copayment per visit	70% of R&C after a $25 Copayment per visit
Acupuncture – up to twelve (12) visits per Policy Year. Visit limits do not apply for chemical dependency treatment.	80% of PA	50% of R&C
Respiratory Therapy	80% of PA	50% of R&C
Dermatology (not including treatment of acne)	80% of PA	50% of R&C
Podiatry - only when prescribed by the Attending Physician.	80% of PA	50% of R&C
Home Health Care services	80% of PA	50% of R&C
Hospice- Includes fourteen (14) days of respite care for the Family Member acting as primary caregiver.	80% of PA	50% of R&C
Diabetic treatment and education -Includes supplies and services, including but not limited to, test strips, insulin and insulin syringes and glucagon emergency kits.	Paid as any other Sickness	
Prosthetic and Orthotic Devices - Includes replacement, repair, fitting and adjustment.	80% of PA	50% of R&C
Durable Medical Equipment (DME) – Includes cochlear implants. DME for Hospice and/or Home Health Care will be paid the same as Inpatient DME. Coverage for DME includes sales tax.	80% of PA	50% of R&C
Dental treatment due to Injury to a Sound Natural Tooth - Includes emergency treatment; oral surgery due to trauma or injury; and preparation of the jaw for radiation treatment of neoplastic disease.	80% of PA	50% of R&C

Nutritional counseling –up to three (3) visits per Policy Year (except for treatment of diabetes – unlimited).	80% of PA	50% of R&C
Phenylketonuria - Includes diagnosis and formulas for treatment of PKU or similar inherited metabolic disorder.	80% of PA	50% of R&C
TMJ – Treatment for the dysfunction of the temporomandibular joints, including surgery of the jaw to correct or treat TMJ.	80% of PA	50% of R&C
Pediatric Dental and Vision Services for <u>Covered Persons under the age of nineteen (19)</u> – Refer to the Pediatric Vision Services and Pediatric Dental Services provisions in the Policy and Certificate for additional details, including applicable limitations and exclusions.		
Pediatric Dental - preventive & diagnostic services, limited to 1 exam/prophylaxis every 6 month. Includes two limited visual oral assessments/screens per Covered Person under the age of nineteen (19) Also includes: • Topical fluoride treatment – 3 per 12 months for age 6 and under or during orthodontic treatment; 2 per 12 months for age 7+; • X-rays-bitewing- 1 set per 12 months; • X-rays-full mouth complete or panoramic-1 per 36 months • Sealants, as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months; • Oral hygiene instruction – 2 per 12 months for ages 8 and under (if not billed on the same day as prophylaxis); • Space maintainers for missing primary molars only. Replacements covered on a case by case basis.		100% of R&C
Pediatric Dental – basic restorative services. Includes: • Fillings (amalgam, resin-based composite) - 1 per tooth per 24 months • Prefabricated stainless steel crown – 1 per tooth per 36 months for primary anterior teeth (prior authorization required for ages 13+) and permanent posterior teeth; • Crowns* - metal/porcelain and porcelain on anterior teeth only; • Periodontics*- scaling and root planning and periodontal maintenance; limited to 1 every 24 months for ages 13+; • Endodontics - pulp cap; therapeutic pulpotomy; • Prosthodontics – denture repair, denture rebase/reline (1 per 36 months; 6 months after initial installation); • Emergency palliative treatment of pain; • Simple extractions; *Requires pre-authorization		70% of R&C
Pediatric Dental – major services. Includes: • Prosthodontics* - bridges* and dentures*: resin based partial denture limited to 1 per 36 months; complete upper and lower 1 per 60 months (one replacement denture per lifetime); • Endodontics - root canals on baby primary posterior teeth only*; root canals on permanent teeth* (excluding teeth 1, 16, 17 and 32); • Periodontics* – including gingivectomy or gingivoplasty; • Oral surgery, including frenulectomy/frenuloplasty for ages 6 and under; • General anesthesia and IV sedation* – in conjunction with complex oral surgery; • Analgesia or non-IV conscious sedation (not in conjunction with general anesthesia or IV sedation); *Requires pre-authorization		50% of R&C
Pediatric Dental – Medically Necessary orthodontia services*, for Covered Persons under nineteen (19), as indicated in the Policy. *Requires pre-authorization		50% of R&C
Frequency limitations may apply. Benefits are provided in accordance with state requirements.		

Routine Vision - Includes: • 1 exam/fitting per Policy Year, including dilation if professionally indicated; • Prescription eyeglasses (lenses and frames), or one pair of Medically Necessary contact lenses or a one year supply of disposable contact lenses in lieu of eyeglasses, limited to once per Policy Year; • Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.	100% up to $150; 50% thereafter

Outpatient Prescription Drugs

Retail Prescription Drugs - per prescription or refill, subject to dispensing limits.

Note: Retail Prescription Drugs will be considered an Essential Health Service unless prescribed drug is related to an Elective Treatment, subject to exclusions and other limitations of the Policy.

3 Tier Plan **The Pharmacy Benefits Manager (PBM) is: Cigna Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
1. Generic Drugs	100% after a $25 Copayment	Not covered
2. Preferred Brand Drugs	100% after a $35 Copayment	Not covered
3. Non-Preferred Brand & Specialty Drugs	100% after a $55 Copayment	Not covered

The PBM uses clinical, economic, and other factors to determine the Prescription Drugs to be included in or excluded from its drug Formulary.

The following method and frequency is used to review the contents of the drug Formulary: At least once each quarter, a pharmacy and therapeutics (P&T) committee reviews the published data on new and existing drugs, and provides clinical guidance to a non-clinical committee that decides the Copay or Coinsurance tiers in which covered drugs will be placed. The clinical review includes evaluation of published medical literature and FDA-approved labeling on the drug, including its pharmacokinetics, clinical efficacy, comparative efficacy, adverse drug reactions, drug interactions, and dosing.

While a Covered Person is not involved in determining which drugs are included in the Formulary, a Covered Person has the right to appeal denials of claims for Prescription Drugs in accordance with the Policy. Covered Persons may also contact a Customer Service Representative (CSR) at the phone number on Your pharmacy identification card with questions regarding the Formulary or to request a copy of the Formulary.

- Only a thirty (30) day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy;
- One (1) Copayment per thirty-one (31) day supply; $0 Copayment for Generic Contraceptives at a Participating Pharmacy only;
- The Covered Person will be responsible for the cost difference between Brand and Generic, in addition to the Tier Copayment for a Brand drug when there is a Generic equivalent available unless "Do Not Substitute" or "Dispense as Written" is indicated on the prescription;
- Includes prescription contraceptives, prescription sterilization, and contraceptive devices (including insertion and extraction) which have been approved by the FDA; prescribed pre-natal vitamins and smoking deterrent prescription medications;
- Includes medications, equipment and supplies for the management and treatment of diabetes;
- Specialty Drugs
- Includes preventive medications including, but not limited to, aspirin, fluoride, and iron;
- ADD and ADHD-related drugs are covered;
- The Deductible does not apply.

Elective Treatment

Elective termination of pregnancy	80% of PA	60% of R&C
Out of country coverage – non-emergency medical treatment, if not covered by any other coverage. Maximum benefit $20,000 per Policy Year.	50% of charges.	
Medical Evacuation/Repatriation (unlimited).	100% of charges	
Includes family travel benefit of $5,000 per Policy Year.	100% of charges	
Dental services for impacted or infected wisdom teeth.	80% of R&C – up to a maximum of $125 per tooth, maximum of $500 per Policy Year.	
Injury sustained while (a) participating in any intramural, intercollegiate, professional, semi-professional or club 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.	80% of PA	50% of R&C

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.
4. **Itemized medical bills should be mailed promptly to Cigna at the address listed.**

SUBMIT ALL CLAIMS TO:
Cigna
PO Box 188061
Chattanooga, TN 37422-8060
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.

Your out-of-pocket costs may be lower when you utilize Cigna PPO Providers. For a listing of Cigna PPO Providers, go to www.cigna.com or contact Consolidated Health Plans at (413) 773-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.

There is no utilization review performed on this Policy.

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: S212514

CLAIM 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 you were notified of the adverse benefit determination. 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

Servicing Agent:
Wells Fargo Insurance Services USA, Inc., Student Insurance Division
10940 White Rock Rd., 2nd Floor
Rancho Cordova, CA 95670
(800) 853-5899
studentinsurance@wellsfargo.com

This plan is underwritten by and offered by:

NATIONWIDE LIFE INSURANCE COMPANY

Columbus, OH

Policy Number: 302-010-4614

For a copy of the privacy notice you may go to:

www.consolidatedhealthplan.com/about/hipaa

Or

Request one from the Health Office at your School

(Please indicate the school you attend with your written request)

Representations of this plan must be approved by the Company.

VALUE ADDED SERVICES

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.chpstudent.com

***ASK MAYO CLINIC**

Students who enroll and maintain medical coverage in this insurance plan have access to a 24-hour nurse line administered by *Ask Mayo Clinic*. This program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. *Ask Mayo Clinic* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *Ask Mayo Clinic* 24-hour nurse line toll free number will be on the ID card.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 *or* if you are in a foreign country, call collect at: 715.295.9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. 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.