Student Health Insurance Plan

Designed for the Students of
Bethel University

BETHEL
UNIVERSITY

2016-2017

Underwritten by:

Nationwide Life Insurance Company
Columbus, OH

Policy Number: 302-001-2214
Group Number: S220216

Effective Date: 8/10/2016
Policy Anniversary Date: 8/9/2017

Administered by:

CHP Student

Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

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WHERE TO FIND HELP

For Questions About:	Please Contact:
Insurance Benefits Preferred Provider Listings Claims Processing Id Card Requests	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 www.chpstudent.com
Preferred Provider Listings	**First Health** www.firsthealth.com

AM I ELIGIBLE?

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

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. Dependents are not eligible under this plan.

CREDIT HOUR REQUIREMENTS

All College of Arts & Sciences students registered and taking 1 or more credits and **all student athletes** are eligible.

All other students (CAPS/GS/Seminary students) taking 6 or more credit hours are eligible to enroll in the insurance plan on a voluntary basis. Students who wish to enroll in the insurance plan must enroll by the enrollment period deadline date **October 01, 2015**. Enrollment forms and premium payments postmarked by the U.S. postal service after this date will only be accepted for students who qualify for late enrollment. For subsequent terms of coverage, students must enroll no later than 45 days from the first day of the term of coverage for which the student is enrolling.

The following students are not eligible to enroll in the insurance plan: students enrolled exclusively in online courses or whose enrollment consists entirely of short-term courses; students taking distance learning, home study, correspondence, television courses, or courses taken for audit do not fulfill the eligibility requirements that the student actively attend classes. The online restriction does not apply to students who are completing their degree requirements while engaged in practical training.

INVOLUNTARY LOSS OF OTHER COVERAGE

If You are eligible for Coverage but do not enroll in Coverage under this Policy when You first meet the definition of Eligible Person as a result of coverage under another Policy, You may be eligible to enroll in Coverage under this Policy provided enrollment and Premium are received within thirty-one (31) days of Involuntary Loss of Other Coverage.

For purposes of this section, Involuntary Loss of Other Coverage means that prior coverage is involuntarily terminated due to no fault of the Eligible Person, which includes coverage that terminates due to a loss of employment by the Eligible Person or the Eligible Person's spouse or parent. This definition does not include coverage that has a predetermined termination date, or expiration of COBRA eligibility, and does not apply to coverage that has been voluntarily terminated.

Coverage is effective upon enrollment and receipt of Premium by Us or Our authorized representative.

EFFECTIVE DATES AND COSTS

	Annual* 8/10/16 - 8/9/17	Fall* 8/10/16 - 12/31/16	Interim* 1/1/17 - 8/9/17	Spring* 2/1/17 - 8/9/17	Summer* 5/30/17 - 8/9/17
Student	$1,400	$559	$852	$734	$281

**The above rates include an administrative fee.*

TERMINATION

Covered Person: 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 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 We will refund the unearned pro-rata Premium (minus any claims paid) to such person upon written request from the Policyholder.
- The date a Covered Person enters full time active military service. Upon written request, We will refund any unearned pro-rata Premium (minus any claims paid) with respect to such person.

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the Covered Person's Termination Date. However, if a Covered Person is Hospital Confined Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of ninety (90) days or until date of discharge, whichever is earlier.

The total payments made in respect of the Insured 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.

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.

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. See also Preferred Brand Drug and Non-Preferred Brand Drug.

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.

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.

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;
- Who has been accepted for Coverage or has been automatically added;
- For whom the required Premium has been paid; and

- Whose Coverage has become effective and has not terminated.

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

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.

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).

Formulary: A list of Generic, Brand Name, and/or Specialty Prescription Drugs that are Covered under the Policy.

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.

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.

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.

Morbid Obesity: A body mass index that is greater than 40 kilograms per meter squared; or, equal to or greater than 35 kilograms per meter squared with a co-

morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

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.

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 and non-covered and Elective Treatment do not count toward this limit.

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

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.

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.

Preventive Care: Provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations, as specified in the Schedule of Benefits or when ordered or provided by a Physician in accordance with the standard practice of medicine. Well Baby and Child Care, and Well Adult Care Benefits will be considered based on the following:

(a) Evidence-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;

Covered Services include but are not limited to:

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have never smoked;
2. Alcohol Misuse screening and counseling;
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages;
4. Blood Pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal Cancer screening for adults over age fifty (50);
7. Depression screening for adults;
8. Diabetes (Type 2) screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. HIV screening for everyone ages fifteen (15) to sixty-five (65), and other ages at increased risk;
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    a. Hepatitis A
    b. Hepatitis B
    c. Herpes Zoster
    d. Human Papillomavirus
    e. Influenza (Flu Shot)
    f. Measles, Mumps, Rubella
    g. Meningococcal
    h. Pneumococcal
    i. Tetanus, Diphtheria, Pertussis
    j. Varicella
12. Obesity screening and counseling for all adults;
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
14. Syphilis screening for all adults at higher risk;
15. Tobacco Use screening for all adults and cessation interventions for tobacco users.

(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;

(d) Child health supervision services, which means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six (6), and appropriate immunizations from ages six (6) to eighteen (18), as defined by

Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to twelve (12) months, three (3) child health supervision visits from twelve (12) months to twenty-four (24) months, once a year from twenty-four (24) months to seventy-two (72) months.
(e) 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.
(f) Additional information can be found at https://www.healthcare.gov/preventive-care-benefits/ or by calling 1-800-318-2596 / TTY: 1-855-889-4325.

Provider: A Physician, dentist, 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.

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.

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.

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

PPO PLAN - PREFERRED PROVIDER INFORMATION

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

SCHEDULE OF BENEFITS

Actuarial Value: 78.83%
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: First Health Network at www.firsthealth.com.

EFFECTIVE DATE: 8/10/2016 **POLICY ANNIVERSARY DATE**: 8/9/2017

Benefits	In-Network Benefit	Out-of-Network Benefit
Maximum Benefit	Unlimited	
Deductible (except as specified herein) per Condition per Covered Person. • Benefits are subject to Deductible unless otherwise indicated. • The Deductible shall not apply: o In-network Preventive/wellness exams and immunizations. o To Covered Services performed at the Student Health Center • Copayments do not apply to Deductibles.	$200	$400
Insured Percent (except as specified herein)	80% of the Preferred Allowance (PA)	60% of the Reasonable and Customary Charges (R&C)
Student Health Center	100% of charges incurred; In-Network Deductible waived	
Out-of-Pocket Maximum per Covered Person. • Includes Coinsurance, Copayments and Deductibles; • Excludes Out-of-Network expenses, non-covered medical expenses and Elective Treatment; • 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.	$4,500	None

Covered Charges – Essential Health Benefits		
Preventive Care		
Preventive Services	100% of PA Deductible Waived	60% of R&C
Outpatient Services - Other than Surgery or Maternity Services		
Office visits, 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, including services provided via Telemedicine.	80% of PA after $25 Copayment per visit	60% of R&C after $25 Copayment per visit
Specialists visits	80% of PA after $25 Copayment per visit	60% of R&C after $25 Copayment per visit
Consulting Physician (other than Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician): Limited to one (1) visit per day Does not apply when related to Surgery	80% of PA after $25 Copayment per visit	60% of R&C after $25 Copayment per visit
Diagnostic Imaging - Includes x-ray services which are diagnostic or therapeutic.	80% of PA	60% of R&C
Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.	80% of PA	60% of R&C
CT Scan, MRI, and /or PET Scans	80% of PA after $500 Copayment per Procedure	60% of R&C after $500 Copayment per Procedure
Infusions (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	60% of R&C
Injections (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	60% of R&C

Diagnostic Procedures for Cancer Including but not limited to: Prostate Cancer Screening Ovarian Cancer Surveillance Tests for women at risk for ovarian cancer. At risk for ovarian cancer" means: (1) having a family history: (i) with one or more first or second-degree relatives with ovarian cancer; (ii) of clusters of women relatives with breast cancer; or (iii) of nonpolyposis colorectal cancer; or (2) testing positive for BRCA1 or BRCA2 mutations. (b) "Surveillance tests for ovarian cancer" means annual screening using: (1) CA-125 serum tumor marker testing; (2) transvaginal ultrasound; (3) pelvic examination; or (4) other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.).	80% of PA	60% of R&C
Radiation	80% of PA	60% of R&C
Chemotherapy	80% of PA	60% of R&C
Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - Includes administration and supplies.	80% of PA	60% of R&C

Inpatient Services – Other than Surgery or Maternity		
Miscellaneous Hospital Services - Includes meals and prescribed diets, Diagnostic Imaging, Laboratory, pharmaceuticals administered while an Inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical event, Pre-Admission Testing and Inpatient Rehabilitation.	80% of PA	60% of R&C
Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital.	80% of PA	60% of R&C
Intensive Care Room	80% of PA	60% of R&C
Physician visit, during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility. Limited to one (1) visit per day Does not apply when related to surgery	80% of PA	60% of R&C
Specialist visit	80% of PA	60% of R&C

Consulting Physician, when requested and approved by the Attending Physician. Limited to one (1) visit per Consulting Physician per day.	80% of PA	60% of R&C
Skilled Nursing Facility and Sub-Acute Care Facility Includes semi-private room and board, general nursing services, meals and prescribed diets, supplies, Diagnostic Imaging, laboratory, Rehabilitation.	80% of PA	60% of R&C
Inpatient Rehabilitation Facility - Includes Physical Therapy, Occupational Therapy, Cardiac therapy, and Pulmonary Therapy which is expected to result in significant return of function.	80% of PA	60% of R&C
Surgical Services		
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 more than one (1) incision at the same operative session, We will pay an amount not to exceed the Benefit for the primary or most expensive procedure and 50% of the Benefit otherwise payable for the secondary procedures.		
Inpatient Surgical Services		
Surgeon	80% of PA	60% of R&C
Assistant Surgeon	25% of Surgeon's payment	25% of Surgeon's payment

Anesthetist Services	25% of Surgeon's payment	25% of Surgeon's payment
Inpatient Surgical Miscellaneous - Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	80% of PA	60% of R&C
Outpatient Surgical Services		
Surgeon	80% of PA	60% of R&C
Assistant Surgeon	25% of Surgeon's payment	25% of Surgeon's payment
Anesthetist Services	25% of Surgeon's payment	25% of Surgeon's payment
Outpatient Surgical/Day Surgery Miscellaneous - Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.	80% of PA after $500 Copayment per surgical event	60% of R&C after $500 Copayment per surgical event

Other Surgical Services (Inpatient/Outpatient)		
General Anesthesia for Dental services	80% of PA	60% of R&C
Reconstructive Surgery Including, but not limited to: • Surgery to correct a congenital defect, disease or anomaly that improves physical function; • Nevus flammeus or "port-wine stain" removal • Post mastectomy reconstructive surgery on the impacted breast, as well as surgery on the second breast to achieve symmetrical appearance and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient	80% of PA	60% of R&C
Organ Transplant Surgery - Includes kidney, cornea, heart, lung, heart/lung, liver, bone marrow, pancreas and kidney/pancreas transplants; Donor expenses related to the recipient Covered Person are covered. **Note:** Excludes treatment of medical complications of the donor.	80% of PA	60% of R&C

Reproductive Services		
Infertility Services - Includes diagnostic procedures and tests, office visits and consultations to diagnosis infertility, Excludes infertility treatment.	80% of PA	60% of R&C
Contraceptives, including devices and related procedures, except as provided under the Prescription Drug Benefit.	100% of PA & waiver of Deductible	60% 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.		
Routine Prenatal Care Services and tests. "Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.	100% of PA Deductible & Copayments waived	Paid as any other Sickness

Delivery and Inpatient Physician visits for mother and baby	Paid as any other Sickness	Paid as any other Sickness
Diagnostic services performed and billed by a Physician's office, including ultrasounds and amniocentesis.	Paid as any other Sickness	Paid as any other Sickness
Mental Conditions and Alcoholism/Drug Abuse		
Inpatient services - including Alcoholism/Drug detoxification.	Paid as any other Sickness	Paid as any other Sickness
Outpatient Office Visits - Includes partial, residential or day treatment.	Paid as any other Sickness	Paid as any other Sickness
Urgent Care and Emergency Services		
Urgent Care Facility services	80% of PA after $150 Copayment per visit	80% of R&C after $150 Copayment per visit
Emergency services– visits to an Emergency room or Urgent Care for stabilization or the initiation of treatment for an Emergency Condition. Emergency services includes an immediate response service available on a 24-hour, seven-day-a-week basis for each child, or person, having a psychiatric crisis, a mental health crisis, or a mental health emergency. Includes Physician's fees, Diagnostic Imaging, Laboratory, Injections, use of emergency room, supplies and facility charges**.** • **Copayment is waived if admitted to Hospital;** • Follow-up care at the Emergency room is not covered .	80% of PA after $150 Copayment per visit	80% of R&C after $150 Copayment per visit

Emergency Medical Transportation services	80% of PA	60% of R&C
Other Services		
Allergy Testing	80% of PA	60% of R&C
Allergy 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	60% of R&C
Clinical Trials - Includes coverage for routine patient costs associated with a Covered Person's participation in a clinical 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	60% of R&C
Habilitative Care--Only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, Occupational Therapy and Speech Therapy for a function that did not previously exist, but would normally be expected to exist. Limited to one (1) visit per day.	80% of PA	60% of R&C

Rehabilitative Care - Only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, Occupational therapy and Restorative Speech Therapy which is expected to result in significant return of function. Limited to one (1) visit per day	80% of PA	60% of R&C
Pulmonary Therapy	80% of PA	60% of R&C
Cardiac Therapy	80% of PA	60% of R&C
Respiratory Therapy	80% of PA	60% of R&C
Chiropractic care - Only when prescribed by the Attending Physician to diagnose or treat acute neuromuscular-skeletal conditions; Includes x-rays, office visits, laboratory services, manipulations and modalities (i.e., hot packs, cold packs and ultrasounds, etc.), regardless of Provider type. Limited to one (1) visit per day.	80% of PA	60% of R&C

Dermatology - Only when prescribed by the Attending Physician.	80% of PA	60% of R&C
Podiatry - Only when prescribed by the Attending Physician.	80% of PA	60% of R&C
Home Health Care services - Includes services for Covered Persons dependent on a ventilator.	80% of PA	60% of R&C
Hospice - Limited to Covered Persons with a life expectancy of six (6) months or less.	80% of PA	60% of R&C
Diabetic treatment and education	80% of PA	60% of R&C
Durable Medical Equipment (DME) Including, but not limited to: • Prosthetic and orthotic devices (foot orthotics are limited to Covered Persons with diabetes); • One (1) hair prosthesis per Policy Year for Covered Persons who's hair loss is related to chemotherapy or radiation therapy for the treatment of cancer or those with alopecia areata; • Prosthetics to address a congenital defect; • Prosthetic breast post mastectomy; • Diabetic supplies and equipment. Coverage excludes repair or replacement if the items are damaged by misuse, are lost or are stolen and excludes sales tax, mailing and delivery fees.	80% of PA after $50 Copayment per Prescription	60% of R&C after $50 Copayment per Prescription

Nutritional Services - Coverage is provided for dietary counseling and treatment for Covered Persons with an inherited metabolic disorder, such as PKU; Includes oral amino acid based elemental formulas.	80% of PA	60% of R&C
Hearing Aids - limited to one (1) hearing aid per ear every thirty-six (36) months and limited to Covered Persons through eighteen (18) years of age.	80% of PA	60% of R&C
TMJ/CMJ - treatment for the dysfunction of the temporomandibular joints, including surgery of the jaw to correct or treat TMJ.	80% of PA	60% of R&C
Lyme Disease Treatment	80% of PA	60% of R&C
Dental treatment due to Injury to a Sound Natural Tooth, not including broken fillings or damage caused by biting or chewing; Treatment must be initiated within six (6) months of Injury and received within twenty-four (24) months.	80% of PA	60% of R&C

Private Duty Nursing Care or personal care assistant to a ventilator-dependent Covered Person in the Covered Person's home, coverage is provided for up to 120 hours of services provided by a private duty nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.	80% of PA	60% of R&C
Scalp Hair Prostheses for hair loss as a result of alopecia areata.	80% of PA	60% of R&C
Routine Eye Exam for Covered Person aged nineteen (19) and older	80% of PA	60% of R&C

Pediatric Dental and Vision Services – 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, for Covered Persons under nineteen (19); Limited to 1 exam / prophylaxis every 6 month. Includes: • Topical fluoride treatment – 2 per 12 months • x-rays – bitewing – 1 set per 6 months • x-rays - full-mouth and panoramic – 1 per 60 months • sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months) • space maintainers	100% of R&C
Pediatric Dental – basic restorative services, for Covered Persons under nineteen (19). Includes: • emergency palliative treatment of pain • fillings (amalgam, resin-based composite) • prefabricated stainless steel crown – 1 per tooth per 60 months • endodontics - therapeutic pulpotomy • periodontics - scaling and root planning, limited to 1 every 24 months • prosthodontics – denture repair, denture rebase/reline (1 per 36 months; 6 months after initial installation) • Oral surgery	70% of R&C

Pediatric Dental – major services, for Covered Persons under nineteen (19). Includes: • prosthodontics - crowns, bridges, and dentures - 1 per tooth/arch every 60 months • endodontics (root canals on permanent teeth limited to one per tooth per lifetime) • periodontics – gingivectomy or gingivoplasty, limited to 1 every 36 months for four or more teeth • general anesthesia and IV sedation – in conjunction with complex oral surgery	50% of R&C
Pediatric Dental – Medically Necessary orthodontia services*, for Covered Persons under the age of nineteen (19) with severe and handicapping malocclusion. Includes: • pre-orthodontic treatment • orthodontic treatment • appliance therapy • orthodontic retention *Requires pre-authorization	50% of R&C
Routine Vision Exam for Covered Persons under the age of nineteen (19). Includes: • 1 exam/fitting per Policy Year, including dilation if professionally indicated • prescription eyeglasses (lenses and frames), or one (1) year supply of contact lens 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% of actual charges up to $150, then 50%

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.	
4 Tier Plan	
Generic Drugs	80% of R&C after $25 Copayment
Preferred Brand Drugs	80% of R&C after $50 Copayment
Non-Preferred Brand Drugs	80% of R&C after $50 Copayment
Specialty Drugs	80% of R&C after $50 Copayment
You will need to file a claim form for reimbursement. Save Your receipt and call Our customer service department to request a form. • 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 (30) day supply. No cost sharing applies to Generic Contraceptives or other Preventive Services drugs. • No cost sharing applies to: 1) Contraceptives which have been approved by the FDA and prescribed by a Provider as Medically Necessary; and 2) other Preventive Services drugs. • Includes prescribed pre-natal vitamins and smoking deterrent prescription medications. • Includes medications, equipment and supplies for the management and treatment of diabetes. • The Deductible does apply. • The Covered Person will be responsible the Tier 2, 3 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.	
Elective Treatment	
Intercollegiate, Club and Intramural Sports	Paid as any other Injury
Non-emergency out-of- Country Coverage **Maximum Benefit**: $20,000 per Policy Year	60% actual charges

COORDINATION OF BENEFITS (COB)

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.

EXCLUSIONS

Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

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, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.
2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids and the fitting or repairing or replacement of hearing aids (except as provided herein or in the case of an 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 of the foot 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 and shoe inserts. except for treatment of Injury, infection or disease.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; 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. Sexual/gender reassignment surgery, except as provided when determined to be Medically Necessary or when treatment is otherwise covered under the Policy in the absence of a diagnosis of gender dysphoria. This exclusion does **not** include related mental health counseling or hormone therapy.
7. 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.
8. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications.
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 while (a) participating in any professional or semi-professional sport, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition.
11. Long-term care.
12. 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.
13. Injury occurring in consequence of riding as a passenger or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline or as a passenger in a Policyholder owned leased chartered or operated aircraft 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.
14. Reproductive/Infertility services, unless caused by Injury or Sickness, including but not limited to: family planning treatment of infertility (male or female) including diagnosis, diagnostic tests, 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. 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.
15. Elective termination of pregnancy.
16. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee.
17. Services for the treatment for any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.
18. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
19. War or any act of war, declared or undeclared; or while in the armed forces of any country.
20. Obesity treatment: Services and associated expenses for the treatment of obesity, except nutrition counseling specifically provided in the Policy, and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:
    - Gastric or intestinal bypasses;
    - Gastric balloons;
    - Stomach stapling;
    - Wiring of the jaw;
    - Panniculectomy;
    - Appetite suppressants;
    - Surgery for removal of excess skin or fat.
21. Acupuncture.
22. 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.
23. Elective Treatment, except as specified in the Schedule of Benefits.

CLAIM PROCEDURES

In the event of Injury or Sickness, students should:

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

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 one hundred eighty (180) days of the date appearing on the EOB. The appeal request must include why the Insured Person disagrees with the way the claim was processed. The request must include any additional information he/she feels supports the request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator, Consolidated Health Plans.

The Plan is Underwritten By:
Nationwide Life Insurance Company
Columbus, OH
Policy Number: 302-001-2214

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800-633-7867
Email: customerservice@consolidatedhealthplan.com
www.chpstudent.com

Servicing Broker:
SAS/Ryan Desch
615-439-7098
Email: ryand@sas-mn.com

For a copy of the Company's 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

The following services are not part of the Plan Underwritten by Nationwide Life Insurance. These value added options are provided by Consolidated Health Plans.

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.