Student Health Insurance Program

Designed for the students of:

SALTERcollege
A Private Four-Year College

Chicopee, MA
West Boylston, MA

2015-2016

NATIONWIDE LIFE INSURANCE COMPANY
Columbus, OH
Policy Number: 302-532-2013
Group Number: S214713

Effective September 1, 2015 to August 31, 2016

PREFERRED PROVIDER NETWORK

By enrolling in this Insurance Program, you have PHCS Preferred Provider Network, except in the Western Massachusetts Counties of Hampden, Hampshire, Berkshire and Franklin where you have the CHP Preferred Provider Network, available to You, through Massachusetts, providing access to quality health care at discounted fees. A complete listing is available at www.phcs.com or www.chpstudent.com. A Preferred Provider may require a Covered Person to pay an annual fee for inclusion within the Preferred Providers panel of patients. Any services that are represented to be a part of the Preferred Provider’s annual service agreement are part of that separate agreement and are not part of this Insurance Program.

THE PROGRAM DOES NOT REQUIRE YOU TO USE A PREFERRED PROVIDER.

If a Preferred Provider is not available in a particular area or specialty, the Policy will cover at the Preferred Provider level until a provider has been added.

Coverage will be provided at the Preferred Provider level for a provider who is not a Preferred Provider for the first 30 days from the effective date of coverage if a Covered Person is undergoing an ongoing course of treatment or the provider is the Covered Person’s primary care provider.

If the Covered Person is a female who is in her 2nd or 3rd trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or fraud, treatment will be allowed with said provider, according to the terms of the Policy, for the period up to and including the Covered Persons first postpartum visit.

If a Preferred Provider is not available in a particular area or specialty, the Policy will cover at the Preferred Provider level until a provider has been added.

If the Covered Person is terminally ill and the provider in connection with said Sickness is involuntarily disenrolled, other than disenrollment for quality-related reasons or fraud, treatment will be allowed with said provider, according to the terms of the Policy, until the death of the Covered Person.

Continued coverage is conditioned upon the provider agreeing to:

• Accept reimbursement at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Covered Person in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; and

• Adhere to the Policy’s quality assurance standards and to provide necessary medical information related to the care provided; and

• Adhere to Our policies and procedures.

Physician profiling information may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

We will provide coverage for pediatric specialty care to Covered Persons requiring such services, including mental health services, by a person with recognized expertise in specialty pediatrics.

STUDENT ELIGIBILITY AND ENROLLMENT

To be eligible for this Insurance Program, You must be enrolled as a full-time Salter College Student, or carry a course load equivalent to at least ¾ full-time (students enrolled in online classes are not eligible for coverage). If You are eligible to be covered under this Program, You are automatically enrolled unless You can certify that You have comparable coverage.

You may enroll in this Insurance Program only during the 31-day periods beginning with the start of the first and second terms. If You are eligible for coverage and wish to enroll in the Program after these enrollment opportunities, You must present documentation from Your former insurance company that it is no longer providing You with personal accident and health insurance coverage. Your effective date under this Program will be the date Your former insurance expired, if You make the request for coverage sixty (60) days after it expires. Otherwise, the effective date will be the 1st of the month following Your request. Your premium for this coverage must accompany the request.

HOW DO I WAIVE/ENROLL

If You are eligible to be covered under this Program, You are automatically enrolled, unless You choose to waive coverage.

To document proof of comparable coverage, students need to complete the online Waiver Form and submit it prior to the start of the school year. To submit the online Waiver Form:

1. Go to www.chpstudent.com;
2. Select Salter College from the drop down box;
3. Click on the Waive or Accept tab;
4. Hit continue; and
5. Complete all information as directed.

This health plan satisfies Massachusetts Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see page 5 for additional information.
You may enroll in this Insurance Program or waive the insurance prior to the start of the School year, or during the thirty-one (31) day period beginning with the date you become eligible under this Plan; this is known as the Open Enrollment Period.

If you are eligible for coverage and wish to enroll in the Plan outside of these enrollment opportunities, you must present documentation from your former insurance company that it is no longer providing you with personal Accident and Sickness insurance coverage.

Your Effective Date of coverage under this Insurance Program will be the date that your former insurance expired, but only if you make the request for coverage within sixty (60) days from the date that your previous plan expired. Otherwise, the Effective Date of coverage under this Insurance Program will be the first (1st) of the month following our receipt of your written request for coverage. The appropriate premium must accompany your application for coverage.

**MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:**

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan satisfies Minimum Creditable Coverage standards that are effective during the term of coverage as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirements that you have health insurance meeting these standards.

**THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.**

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

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**LATE WAIVER/WAIVER APPEAL PROCESS**

After the deadline, the Student Health Plan may not be waived/cancelled, except as provided by policy guidelines. Call the (Student Accounts Office) for more information.

**PREMIUM**

Premium for-coverage must be received within the 31-day period beginning with the start of the first and second terms.

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*Costs above include a fee retained by the Servicing Agent.

**PREMIUM REFUND POLICY**

In the case of medical withdrawal, any insured withdrawing from school must submit documentation or certification of the medical withdrawal to us at least 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 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, or unless required in accordance with Massachusetts Law.

**DEPENDENT ELIGIBILITY AND ENROLLMENT**

Students who are enrolled in the Student Health Insurance Plan may also enroll their Dependents. Dependent coverage, if any, begins and ends with your coverage. A dependent newborn child will be automatically covered under the Policy from the moment of birth until the thirty-first (31st) day following birth. During the thirty-one (31) day period, we must receive written notice of the birth and the required premium must be paid. Coverage for such newborn children will consist of coverage for Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or premature birth, including the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by the regulations of the Department of Public Health. To continue coverage beyond the thirty-one (31) day period or to obtain other Dependent coverage, the Insured must notify us in writing before thirty-one (31) days of birth, marriage, adoption, or other qualifying event, and pay the required additional Premium.

**TERMINATION**

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

- The Termination Date of the Policy;
- The last day of the term of Coverage for which Premium has not been paid;
- The date a Covered Person enters full time active military service. Upon written request within ninety (90) days of leaving school, we will refund a pro-rata Premium to such person.

A Covered Person’s coverage may be cancelled, or its renewal refused, only in the following circumstances: failure by the Covered Person or other responsible party to make payments under the Policy; misrepresentation or fraud on the part of the Covered Person; commission of acts of physical or verbal abuse by the Covered Person which pose a threat to providers or other insureds and which are unrelated to the Covered Person’s physical or mental condition; relocation of the Covered Person outside the Policy’s service area; or non-renewal or cancellation of the Policy through which the Covered Person receives coverage or the Covered Person is no longer a student.

**INVOLUNTARY DISENROLLMENT**

The number of Covered Persons involuntarily disenrolled in the past two (2) years is zero (0).
EXTENSION OF BENEFITS

The coverage provided under this policy ceases on the Termination Date shown on the face page. However, if an Insured 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 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 Benefits. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

GENERAL 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.

Biologically Based Mental Illness: A mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Illness. Such biologically based mental illnesses are defined as Schizophrenia; Schizoaffective disorder; Major depressive disorder; Bipolar disorder; Paranoid and other psychotic disorders; Obsessive-Compulsive disorder; Panic disorder; Delirium and dementia; Affective disorders; Eating disorders; Post traumatic stress disorder; Substance abuse disorders; and Autism.

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

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

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

Dependent: A person who is the Insured’s:
- Legally married spouse, who is not legally separated from the Insured and resides with the Insured.
- Child who is under the age of 26 or for 2 years after the end of the calendar year in which such persons last qualified as dependent under 26 U.S.C 106, whichever occurs first.

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

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

Emergency: An Illness, Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, serious jeopardy to the fetus.

A Covered Person has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever a Covered Person is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services. No Covered Person shall in any way be discouraged from using the local pre-hospital emergency medical services system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition. Emergency does not include the recurring symptoms of a Chronic Condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

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.

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.

Health Care Facility: A Hospital, Skilled Nursing, 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 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: 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.

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.

Mental Condition(s): Nervous, emotional, and mental disease, illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a Mental Condition on the date of medical care or treatment is rendered to a Covered Person.

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. The out-of-pocket includes Copayments, Deductibles and Coinsurance. Out-of-Network payments do not count toward this limit.

Physician: A health care professional, including a Physician Assistant, 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.

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.

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. 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. 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.

Provider: A Physician, Nurse Practitioner, Health Care Facility, or Urgent Care Facility that is licensed or certified to provide medical services or supplies. Physician profiling information may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

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 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.

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.

We, Our and Us: Nationwide Life Insurance Company.

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

STUDENT HEALTH INSURANCE

This brochure is a brief description of the Student Health Insurance Plan available for all students who meet the eligibility requirement. The exact provisions governing this insurance are contained in the Master Policy underwritten by Nationwide Life Insurance Company, serviced by administered by Consolidated Health Plans.

Benefits for Covered Medical Expenses will be paid according to the Schedule of Benefits and any exclusions, limitations, or state mandated provisions as follows.

STATE MANDATED BENEFITS

Benefits are subject to applicable deductible, coinsurance, and co-payments as outlined in the Schedule of Benefits.

Autism Spectrum Disorder: Benefits provided for the diagnosis and treatment of autism spectrum disorder (ASD) in individuals. ASD includes any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger’s disorder and pervasive developmental disorders not otherwise specified.

Treatment of autism spectrum disorders includes the following medically necessary care prescribed, provided or ordered for...
an individual diagnosed with an ASD by a licensed Physician or a licensed psychologist:

- **Habilitation or Rehabilitative Care**: Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavioral analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the function of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produces socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

- **Pharmacy Care**: Medications prescribed by a licensed Physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided for other medical conditions.

- **Psychiatric Care**: Direct or consultative services provided by a licensed psychiatrist.

- **Psychological Care**: Direct or consultative services provided by a licensed psychologist.

- **Therapeutic Care**: Services provided by licensed or certified speech therapists, occupational therapist, physical therapists or social workers.

Benefits are payable the same as any other physical illness.

### Biologically Based Mental Disorders

Coverage will be provided the same as any other physical illness for the following Biologically Based Mental Disorders:

1. Schizophrenia;
2. Schizoaffective disorder;
3. Major depressive disorder;
4. Bipolar disorder;
5. Paranoia and other psychotic disorders;
6. Obsessive-Compulsive disorder;
7. Panic disorder;
8. Delirium and dementia;
9. Affective disorders;
10. Eating disorders;
11. Post traumatic stress disorder;
12. Substance abuse disorders; and

#### Bone Marrow Transplants for Breast Cancer

Coverage is provided as any other physical illness for bone marrow transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic breast disease.

#### Breast Reconstruction Incident to Mastectomy

Coverage is provided for construction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the Attending Physician and the patient.

#### Cardiac Rehabilitation Coverage

Coverage is provided for cardiac rehabilitation expense if a Covered Person has documented cardiovascular disease. This benefit includes multidisciplinary treatment provided in either a Hospital or other setting. Treatment must meet standards promulgated by the Commissioner of Public Health. Cardiac rehabilitation must be initiated within 26 weeks after the diagnosis of the disease.

#### Coverage for Human Leukocyte Antigen Testing for Certain Individuals and Patients

Coverage is provided as any other physical illness for Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. Coverage will cover the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the department of public health.

#### Cytological screening and mammograms

Coverage is provided for cytological screening (pap smear) and mammograms, payable as any other physical illness, for Covered female persons:

- One cytological (pap smear) screening for ages 18 and over;
- A baseline mammogram for ages 35 through 39;
- A mammogram every year age 40 and over.

#### Diabetes Diagnosis and Treatment Expense

Coverage is provided for diabetes diagnosis and treatment expense for treatment of insulin dependent, insulin using, gestational and non insulin dependent diabetes. This Benefit includes expense for blood glucose monitors; blood glucose monitoring strips for home use; voice synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; prescribed oral diabetes medications that influence blood sugar levels; laboratory tests, including glycosylated hemoglobin, or HbA1C tests; urinary/protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens, so called; therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified Physician and furnished by a podiatrist, orthotist, prosthetist or pedorthist; supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy.

#### Early Intervention Services

Coverage is provided by certified early intervention specialist for children from birth until their third birthday. Reimbursement of costs for such services is not subject to co-payments, coinsurance or deductibles, however subject to other Policy provision limitations.

#### Hearing Aids for Children

Coverage is provided for hearing aids for children who are 21 years of age or younger when prescribed by a licensed audiologist or hearing instrument specialist. Coverage includes the initial hearing aid evaluation, fitting, adjustments, and supplies, including ear molds up to $2,000 per hearing aid per hearing impaired ear in each 36 month period.

#### Hormone Replacement Therapy and Contraceptive Services

Benefits will be provided for hormone replacement therapy and contraceptive services.

- Coverage is provided for hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration.
- Provides benefits for outpatient Prescription Drugs and devices that provide benefits for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices which have been approved by the United States Food and Drug Administration under the same terms and
conditions as for such other prescription drugs or devices, provided that in covering all FDA approved prescription contraceptive methods.

Hospice for Terminally Ill (Hospice Care): Coverage is provided for licensed hospice services to terminally ill patients with a life expectancy of six months or less. These services shall include, but not be limited to, Physician's services, nursing care provided by or under the supervision of a registered nurse, social services, volunteer services and counseling services provided by professional or volunteer staff under professional supervision.

Infertility Benefits: The diagnosis and treatment of Infertility is payable the same as any other pregnancy related procedures. Infertility-related drugs will not be treated different from those imposed on any other Prescription Drugs. This Benefit includes expense incurred for the following non-experimental infertility procedures:

- Artificial insemination and Intrauterine insemination;
- In vitro fertilization and embryo transfer;
- Gamete Intra-Fallopian transfer;
- Zygote intrafallopian transfer;
- Intracytoplasmic sperm injection for the treatment of male factor infertility;
- Assisted hatching;
- Cryopreservation of eggs; and
- Sperm, egg, and/or inseminated egg procurement and processing, and banking of sperm or inseminated egg, to the extent such costs are not covered by the donor’s insurer, if any. Coverage is not limited to sperm provided by the insured’s spouse.

“Infertility” means the Condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

Maternity expense: Includes expenses for prenatal care, childbirth and post partum care (including well baby care) on the same basis as any other physical illness. Expenses for childbirth include Hospital inpatient care for 48 hours following vaginal delivery and 96 hours following a cesarean section. Any decision to shorten maternity stays will be made by the Attending Physician in consultation with the mother, in accordance with regulations promulgated by the Department of Public Health. The Covered Person is entitled to one home visit should they elect to participate in an early discharge. Attending Physician includes the attending obstetrician, pediatrician, or certified nurse midwife attending the mother and newly born child.

Mental Health Benefits for Children and Adolescents under age 19: Coverage will be provided the same as any other physical illness for children and adolescents under age 19 for the diagnosis and treatment of non-Biologically-Based Mental, behavioral or emotional disorders, as described in the most recent edition of the DSM. The following requirements must be met:

- The disorders substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care Physician, primary pediatrician or a licensed mental health professional.
- The child or adolescent is evidenced by conduct, including, but not limited to: (1) an inability to attend school as a result of such a disorder; (2) the need to hospitalize the child or adolescent as a result of such a disorder, or (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

Benefits will continue to be provided to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment, as specified in said adolescent's treatment plan, is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

Newborn Hearing: Coverage is provided for the cost of a newborn hearing screening test performed before the newborn infant is discharged from the Hospital or birthing center to the care of the parent or guardian or as provided by regulations of the department of public health.

Non-Prescription Enteral Formulas for Home Use: Coverage is provided for nonprescription enteral formulas for home use for which a Physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Nurse Midwife Coverage: Benefits provided for services of a certified nurse midwife; provided, however, that expenses for such services are reimbursed when such services are performed by any other duly licensed practitioner; and provided, further, that such services are within the lawful scope of practice for a certified nurse midwife.

Off-Label Use of Drugs for the treatment of Cancer and HIV/AIDS: Coverage is provided for the off-label use of drugs for the treatment of cancer and HIV/AIDS.

- Coverage provided for any such drug used for the treatment of cancer on the grounds that the off-label use of the drug has not been approved by the United States Food and Drug Administration for that indication; provided, however, that drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner.

- Coverage provided for any such drug for HIV/AIDS treatment on the grounds that the off-label use of the drug has not been approved by the federal Food and Drug Administration for that indication, if the drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner.

Oral Cancer Therapy: When coverage is provided for cancer chemotherapy treatment, coverage is provided at the same Benefit level for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on a basis not less favorable than intravenously administered or injected cancer medications that are covered.

Other Mental Disorders: Mental Illness treatment of all other mental disorders, which are described in the most recent edition of DMS, consisting of inpatient, intermediate and outpatient services, including home-based services delivered in such offices or settings rendered by a licensed mental health professional acting within the scope of his license, that permit active and noncustodial treatment to take place in the least restrictive clinically appropriate setting.

Inpatient Services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental Hospital licensed by the Department of Mental Health, or in a substance abuse facility licensed by the Department of Public Health.
Intermediate Services means a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient’s needs. Intermediate Services, include, but are not limited to the following: acute and other residential treatment; clinically managed detoxification services; partial hospitalization; intensive outpatient programs; day treatment; crisis stabilization; in-home therapy services.

The duration of authorized intermediate care services will vary according to that person’s individual needs. Authorizations are based on Medical Necessity rather than any arbitrary number of days or number of visits.

Preventive and Primary Care Services: Coverage is provided for the following services to the dependent child of an Insured from the date of birth through the attainment of six (6) years of age:

- Physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six (6) times during the child’s first year after birth, three (3) times during the next year, annually until age six.
- Such services also include hereditary and metabolic screening at birth, screening for lead poisoning, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician.

Coverage is provided for pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to Insureds requiring such services.

Prosthetic Coverage: Coverage provided for prosthetic devices and repairs under the same terms and conditions that apply to other Durable Medical Equipment covered under the Policy, except as otherwise provided in this section. "Prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or leg.

Psychopharmacological and Neuropsychological Assessment Service: Coverage is provided for Psychopharmacological services and neuropsychological assessment services expenses.

Qualified Clinical Trials: Coverage and reimbursement for patient care services provided pursuant to a qualified clinical trial to the same extent as they would be covered and reimbursed if the patient did not receive care in a qualified clinical trial.

Rape Related Mental or Emotional Disorders: Coverage will be provided for the diagnosis and treatment of rape-related or emotional disorders to victims of a rape or victims of assault with intent to commit rape, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims.

Scalp Hair Prosthesis for Cancer Patients: Coverage provided for scalp hair prosthesis expense for prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, payable up to one (1) per Policy Year. "Prosthesis," an artificial appliance used to replace a lost natural structure; provided, however, that prostheses shall include, but not be limited to, artificial arms, legs, breasts, scalp hair or glass eyes.

"Scalp hair prosthesis," an artificial substitute for scalp hair.

Special Medical Formulas: Coverage provided for newly born infants and adoptive children prescribed by a Physician and are medically necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria.

Speech, Hearing, and Language Disorders: Coverage is provided for the diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech language pathologists or audiologists if such services are rendered within the lawful scope of practice for such speech language pathologists or audiologists regardless of whether the services are provided in a Hospital, clinic or private office. Benefits are payable the same as any other Sickness. Coverage does not extend to the diagnosis or treatment of speech, hearing and language disorders in a school based setting.

Telemedicine: Coverage is provided for the delivery of health care services by the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. It does not include the use of audio-only telephone, facsimile machine, or email.

Treatment of Cleft Palate and Cleft Lip for Children: Coverage is provided for the treatment of cleft palate and cleft lip for children under the age of 18. Coverage includes medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment and prosthetic management therapy, speech therapy, audiology, and nutrition services when medically necessary services are prescribed by the treating Physician or surgeon.

EMERGENCY 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 or if a Covered Dependent sustains an Accidental Injury or Emergency Sickness and is more than a 100 mile radius from his current place of primary residence or outside of his Home Country, We will pay for the actual 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.

FAMILY TRAVEL BENEFIT

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

1. to bring one person designated by the Insured to and from the Hospital or other medical facility where the Insured is Confined if the Insured is alone and if the place of Confinement is outside a 200 mile radius from the Insured’s primary place of residence. Expenses will be limited to the cost for one economy round-trip airline ticket to, the place of the Hospital Confinement. Payment for meals, ground transportation and other incidentals are the responsibility of the Family Member or friend. With respect to any one (1) trip, this benefit is payable only once for that trip, regardless of the number of Covered Persons on that trip. No more than one (1) visit may be made during any 12 month period.

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

The determination of whether the Insured Person will be hospitalized for more than five (5) days or is in critical condition shall be made by Us after consultation with the attending Physician.

All transportation arrangements made must be by the most direct and economical conveyance and route possible.

**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.

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.

**GENERAL EXCLUSIONS AND LIMITATIONS**

Unless specifically included, no Benefits will be paid for:

a) loss or expense caused by, contributed to, or resulting from;
b) treatment, services, or supplies for, at, or related to:
1. Eyeglasses, contact lenses, routine eye refractions, eye examinations except as in the case of Injury. 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; hearing aids and the fitting, 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 of the foot including, but not limited to, weak feet or fallen arches, flat or pronated foot, subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions, any type of massage procedure on or to the foot, corrective shoes, shoe inserts and orthotics.
5. 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 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; rhinoplasty; sagging eyelids; prominent ears; skin scars; baldness; and correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections).

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

7. Custodial Care.
8. Treatment on or to the teeth or gums (except as specified herein).
9. 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.
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.
11. Injury resulting from travel in or upon parachuting, hang gliding, skydiving, parasailing, scuba diving, skin diving, speed contests, or bungee jumping.
12. Injury occurring in consequence of riding 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.
13. Reproductive services, unless caused by Injury or Sickness, including but not limited to: premarital examination; impotence, organic or otherwise;
14. sterilization (except as specifically provided in the Policy) sterilization reversal; vasectomy/vasectomy reversal, except as specifically provided in this Policy.
15. Elective termination of pregnancy.
16. Hospital Confinement or any other services or treatment that You or Your Dependent(s) are not legally obligated to pay; or for which no charge is made.
17. Services provided normally without charge by the health service of the Policyholder, or services covered or provided by the Student Health Fee.
18. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
19. Any services of a Doctor, Nurse, or Health Care Practitioner who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.
20. Services received after the Insured’s Coverage ends, except as specifically provided under the Extension of Benefits provision.
21. Under the Prescription Drug Benefit, any drug or medicine:
   a. Obtainable Over the Counter (OTC);
   b. For the treatment of alopecia (hair loss) or hirsutism (hair removal);
   c. For the purpose of weight control;
   d. Anabolic steroids used for body building;
   e. Sexual enhancement drugs;
   f. 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;
   g. Treatment of nail (toe or finger) fungus;
   h. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
   i. For an amount that exceeds a 30 day supply;
   j. Drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
   k. Purchased after Coverage under the Policy terminates;
   l. Consumed or administered at the place where it is dispensed;
   m. if the FDA determines that the drug is:
the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If We fail to comply, We are required to pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning forty-five (45) days after receipt of the properly documented at the rate of 1.5 percent per month, not to exceed eighteen (18) percent per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

There is no utilization review performed on the 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: S214713

You can access up to date information about your plan, including amendments, Provider directory, privacy notice, and rights and responsibilities at this website address.

COMPLAINT AND APPEAL PROCEDURES
To file a complaint or to appeal a claim, send a letter stating the issue to Consolidated Health Plan’s Appeal Department at the below address. Include your name, phone number, address, school attended and email address, if available.

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540 or
Toll Free (800) 633-7867
www.chpstudent.com

Appeals must be received within 180 days of the date the student receives written notification of the claim denial. You also have the right to appeal to the Office of Patient Protection at 1-800-436-7757, fax: 1-617-624-5046 or visit www.state.ma.us/dph/opp.

You may request an Urgent Appeal. This request may be verbal or written. A decision will be made within seventy-two (72) hours of receipt for an Urgent Appeal. Under certain circumstances, You also have a right to an external appeal of a denial of coverage.

If You need help filing an internal appeal or external review, Your state’s Consumer Assistance Program (CAP) or Department of Insurance may be able to help You. To find help in Your state, go to www.HealthCare.gov/consumerhelp and click on Your state. The HealthCare.gov website also has information about other consumer protections and health care coverage options created by the Affordable Care Act.

The Plan is underwritten by:
NATIONWIDE LIFE INSURANCE COMPANY
Policy Number: 302-532-2013

VALUE ADDED SERVICES

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE
FrontierMEDEX ACCESS services is a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence. FrontierMEDEX is your key to travel security.

For general inquiries regarding the travel assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867.

If you have a medical, security, or travel problem, simply call FrontierMEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 1-800-527-0218 or if you are in a foreign country, call collect at: 1-410-453-6330.

If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center. FrontierMEDEX will then take the appropriate action to assist You and monitor Your care until the situation is resolved.
NOTICE REGARDING TRANSLATOR AND INTERPRETER SERVICES

We provide, upon request, interpreter and translation services related to administrative procedures and claims processing. This service is available to you when you contact our Customer Service Department at 1-800-MED-STOP.

French/Français

Avis sur les services de translation et d’interprétation

Nous fournissons, sur demande, des services d’interprétation et de translation relatifs aux procédures administratives et au traitement des réclamations. Ce service est à votre disposition quand vous contactez notre service après-vente (Customer Service Department) à 1-800-MED-STOP.

Arabic

Arabic/عربي

إشعار بشأن خدمات الترجمة والترجمة الفورية

إذا قومت، تلبية لطلب الراغبين، خدمات الترجمة والترجمة الفورية المتعلقة بإجراءات الإدارة وتصدير المطالبات. وعندما تسمح، على موافقتك على notre Customer Service Department على الرقم: 633-7867.

Cambodian(Khmer)/ភាសាខ្មែរ

ការប្រឈមឈើដ៏រុក្ីរុក្ីពិនិត្យនៅក្នុងការផ្ទុកនៅក្នុងការមើលការធ្វើការ

បង្កើតបញ្ជាក់ថាជាសេវាព័ត៌មាននៃការផ្ទុកនៅក្នុងការមើលការធ្វើការ

Chinese(Mandarin)/國語

翻譯及傳譯服務通知

如果您提出要求，我們可以為您提供與行政手續和索賠申請有關的翻譯及傳譯服務。請與我們的客戶服務部聯絡，電話是1-800-633-7867（1-800-MED-STOP）。

Notice Regarding Translator and Interpretation Services

Notice Regarding Translator and Interpretation Services

We provide, upon request, interpreter and translation services related to administrative procedures and claims processing. This service is available to you when you contact our Customer Service Department at 1-800-MED-STOP.
<table>
<thead>
<tr>
<th>Policy Year Maximum Benefit</th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Year Deductible - per Individual or Family (applies unless otherwise stated, additional deductibles and co-pays may apply)</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Coinsurance Maximum per Policy Year per Covered Person/per Family</td>
<td>$5,000 per Individual/$10,000 per Family</td>
<td>No Limit</td>
</tr>
<tr>
<td>Insured Percent</td>
<td>80% of Preferred Allowance (PA)</td>
<td>60% of Reasonable &amp; Customary (R&amp;C)</td>
</tr>
<tr>
<td>Preventive/Wellness &amp; Immunization Services</td>
<td>100% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician visits, including Specialists and Consultants</td>
<td>100% of PA after $25 co-pay per visit</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>X-ray and Laboratory Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic Imaging, including CT Scan, MRI, and/or PET Scans</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Miscellaneous Outpatient Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Hospital Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Room and Board expense at the semi-private room, general nursing care, and ICU</td>
<td>80% of PA after $150 co-pay per admission</td>
<td>60% of R&amp;C after $150 co-pay per admission</td>
</tr>
<tr>
<td>Physician Visits (includes Specialists/Consultants)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Skilled Nursing and Sub-Acute Care Facilities – maximum of 100 days per Policy Year</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Inpatient Rehabilitation – up to 30 days per Policy Year</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Surgical Services (Inpatient &amp; Outpatient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When Injury or Sickness requires multiple Surgical Procedures through the same incision, we will pay an amount not less than that for the most expensive procedure being performed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Care – includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided.</td>
<td></td>
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</tr>
<tr>
<td>Emergency Medical Transportation services</td>
<td>80% of R&amp;C</td>
<td></td>
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<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing &amp; Treatment</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Physical, Speech and Occupational Therapy (Outpatient) – maximum of 60 visits each per Policy Year.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Chiropractic – maximum of 20 visits per Policy Year</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospice</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diabetic treatment and Education</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) / Prosthetic Appliances</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hearing Aids for children 21 years of age or younger -up to $2,000 per hearing impaired ear every 36 months</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Prescription Drug Expense (Policy year deductible does not apply)</td>
<td>100% after:</td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Expense (Policy year deductible does not apply)</td>
<td></td>
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</tr>
<tr>
<td>Prescriptions must be filled at a “Catamaran” participating pharmacy. A directory of participating pharmacies is available by calling Catamaran directly at (800) 248-1062. No Co-pay for generic contraceptives and wellness prescriptions</td>
<td></td>
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<tr>
<td>Pediatric Dental for Covered Persons under nineteen (19)</td>
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</tr>
<tr>
<td>Routine Vision Exam for Covered Persons under nineteen (19) – one exam every two (2) years. Eye glasses/contact lenses not covered.</td>
<td>100% of R&amp;C up to $150, 50% thereafter</td>
<td></td>
</tr>
<tr>
<td>Weight Loss programs – up to $150 per Policy Year.</td>
<td>100% of Reimbursable Charge</td>
<td></td>
</tr>
<tr>
<td>Scalp Hair Prostheses – up to 1 per Policy Year</td>
<td>100% of Reimbursable Charge</td>
<td></td>
</tr>
<tr>
<td>Elective Treatment (does not count toward the out of pocket maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Injury (Treatment due to sound, natural teeth)</td>
<td>80% of R&amp;C – up to a maximum of $100 per tooth, maximum of $300 per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Sickness Dental Expense – for removal of impacted or infected wisdom teeth. No other benefits for impacted wisdom teeth will be paid.</td>
<td>80% of R&amp;C – up to a maximum of $125 per tooth, maximum of $500 per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Medical Evacuation and Repatriation</td>
<td>100% of actual charge – no cost sharing</td>
<td></td>
</tr>
<tr>
<td>Non-emergency care when traveling outside of the U.S.</td>
<td>60% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Family Companion</td>
<td>Up to a Maximum of $1,000 per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Bedside Visit (for one companion) when Covered Person is confined inpatient. Benefit (travel and lodging expenses) is limited to $500 per Policy Year.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SALTER COLLEGE -- 2015-2016 SCHEDULE OF BENEFITS**