Student Health Insurance
Designed for the California Students of

2016-2017

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH
Policy Number: 302-900-0414

Effective: August 25, 2016 – August 24, 2017
Group Number: S211715

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

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

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Am I Eligible?</td>
<td>3</td>
</tr>
<tr>
<td>How do I Waive/Enroll?</td>
<td>3-4</td>
</tr>
<tr>
<td>Effective Dates and Cost</td>
<td>4</td>
</tr>
<tr>
<td>Termination of Benefits</td>
<td>5</td>
</tr>
<tr>
<td>Premium Refund Policy</td>
<td>5</td>
</tr>
<tr>
<td>Pre-Certification Process</td>
<td>5-6</td>
</tr>
<tr>
<td>Extension of Benefits</td>
<td>6-7</td>
</tr>
<tr>
<td>Schedule of Benefits</td>
<td>7-21</td>
</tr>
<tr>
<td>Mandated Benefits</td>
<td>21</td>
</tr>
<tr>
<td>Preferred Provider Information</td>
<td>22</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>22</td>
</tr>
<tr>
<td>Subrogation and Recovery Rights</td>
<td>22-23</td>
</tr>
<tr>
<td>Exclusions</td>
<td>23-25</td>
</tr>
<tr>
<td>Definitions</td>
<td>26-31</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Benefit</td>
<td>31-32</td>
</tr>
<tr>
<td>Medical Evacuation Benefit</td>
<td>32</td>
</tr>
<tr>
<td>Repatriation of Remains Benefit</td>
<td>32</td>
</tr>
<tr>
<td>Claim Procedures</td>
<td>32-33</td>
</tr>
<tr>
<td>Claims Appeal Process</td>
<td>33</td>
</tr>
<tr>
<td>Value Added Services</td>
<td>34-35</td>
</tr>
</tbody>
</table>
For questions about claims status, eligibility, enrollment and benefits please contact:

<table>
<thead>
<tr>
<th>For Questions About:</th>
<th>Please Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td><a href="http://www.gallagherstudent.com/aada">www.gallagherstudent.com/aada</a></td>
</tr>
<tr>
<td>Insurance Benefits</td>
<td>Consolidated Health Plans</td>
</tr>
<tr>
<td>Preferred Provider Listings</td>
<td>Springfield, Massachusetts 01104</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>(800) 633-7867</td>
</tr>
<tr>
<td>ID cards</td>
<td><a href="http://www.chpstudent.com">www.chpstudent.com</a></td>
</tr>
<tr>
<td>Preferred PPO Provider Listings</td>
<td>Cigna</td>
</tr>
<tr>
<td>Prescription Drug Providers</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
</tbody>
</table>

**AM I ELIGIBLE?**

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

All registered domestic students are automatically enrolled in this insurance Plan at registration and the premium for coverage is added to their tuition billing, unless proof of comparable coverage is provided by the deadline. All registered international students are automatically enrolled in this insurance Plan at registration and the premium for coverage is added to their tuition billing. Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirements. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium, minus any claims paid.

**HOW DO I WAIVE/ENROLL?**

To document proof of comparable coverage or to enroll in the Student Injury and Sickness Insurance Plan an online waiver/enrollment form must be completed and submitted by the deadline.

**WHERE TO FIND HELP**

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

<table>
<thead>
<tr>
<th>For Questions About:</th>
<th>Please Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td><a href="http://www.gallagherstudent.com/aada">www.gallagherstudent.com/aada</a></td>
</tr>
<tr>
<td>Insurance Benefits</td>
<td>Consolidated Health Plans</td>
</tr>
<tr>
<td>Preferred Provider Listings</td>
<td>Springfield, Massachusetts 01104</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>(800) 633-7867</td>
</tr>
<tr>
<td>ID cards</td>
<td><a href="http://www.chpstudent.com">www.chpstudent.com</a></td>
</tr>
<tr>
<td>Preferred PPO Provider Listings</td>
<td>Cigna</td>
</tr>
<tr>
<td>Prescription Drug Providers</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
</tbody>
</table>

**EFFECTIVE DATES AND COSTS**

The American Academy of Dramatic Arts Student Health Insurance Plan provides coverage to students for a twelve (12) month period - from 12:01 a.m. August 25, 2016, through August 24, 2017.

<table>
<thead>
<tr>
<th></th>
<th>Fall First Year</th>
<th>Winter First Year</th>
<th>Second Year</th>
<th>Third Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8/25/16 - 8/24/17</td>
<td>1/1/17 - 8/24/17</td>
<td>8/25/16 - 7/19/17</td>
<td>7/20/16 - 7/19/17</td>
</tr>
<tr>
<td>Student</td>
<td>$1,280</td>
<td>$840</td>
<td>$1,158</td>
<td>$1,280</td>
</tr>
</tbody>
</table>

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

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

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

Termination is subject to the Extension of Benefits provision.

**PREMIUM REFUND POLICY**

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

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

**PRE-CERTIFICATION PROCESS**

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

You are responsible for calling the Review Organization at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services, the call should be made prior to Hospital Confinement. In the case of an Emergency, the call should take place as soon as reasonably possible. Pre-Certification is not required for Medical Emergency, Urgent Care, or Hospital Confinement for maternity care.

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

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

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

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

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

Failure by the Review Organization agent to make a determination within the time periods prescribed shall be deemed to be an adverse determination subject to appeal.

If You have questions about Your Pre-Certification status, You should contact Your Provider.

**EXTENSION OF BENEFITS**

The Coverage provided under this Policy ceases on the termination date, shown on the face page. However, if a Covered Person is Hospital Confined on the Termination Date for an Injury or Sickness for which Benefits were paid under this Policy prior to the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of thirty (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. Dependents that are newly acquired during the Insured’s Extension of Benefits period are not eligible for Benefits under the provision.

**SCHEDULE OF BENEFITS**

| Actuarial Value: 81.18% |
| 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) & Review Organization for Your Coverage is: Cigna (www.cigna.com).

**EFFECTIVE DATE: 8/25/2016**  **TERMINATION DATE: 8/24/2017**

<table>
<thead>
<tr>
<th>Policy Year Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>In-Network Benefit</td>
</tr>
<tr>
<td>Deductible (except as specified herein) per Policy Year per Covered Person</td>
</tr>
</tbody>
</table>

Benefits are subject to Deductible unless otherwise indicated. The Deductible shall not apply:
- In-Network Preventive/wellness exams and immunizations
- To Outpatient Prescription Drugs
- In-Network Office Visits

Copayments do not apply to Deductibles

<p>| Insured Percent (except as specified herein) | 80% of Preferred Allowance (PA) | 60% of Reasonable &amp; Customary (R&amp;C) |</p>
<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes Coinsurance, Copayments and Deductibles</td>
</tr>
<tr>
<td>Out-of-Network Emergency Services (including Emergency Transportation Services) apply to the In-Network Out-of-Pocket maximum;</td>
</tr>
<tr>
<td>Excludes non-covered medical expenses and Elective Treatment;</td>
</tr>
<tr>
<td>Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year;</td>
</tr>
<tr>
<td>Once the In-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network;</td>
</tr>
<tr>
<td>Once the Out-of-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% Out-of-Network.</td>
</tr>
</tbody>
</table>

$6,600 per Covered Person  
$13,200 per Covered Person
<table>
<thead>
<tr>
<th>Preventive Care (See Definition for additional information.)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>100% of PA Deductible &amp; Copayment waived</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Services - Other than Surgery or Maternity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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. Includes Specialists.</td>
<td>100% of PA after a $50 Copayment per visit + waiver of Deductible</td>
</tr>
<tr>
<td>Consulting Physician - Does not apply when related to surgery.</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Diagnostic Imaging - Includes x-ray services which are diagnostic or therapeutic.</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.</td>
<td>80% of PA</td>
</tr>
<tr>
<td>CT Scan, MRI, and /or PET Scans</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Infusions (done in an Outpatient Health Care Facility or Physician’s office)</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Injections (done in an Outpatient Health Care Facility or Physician’s office)</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Radiation</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Dialysis (hemodialysis and peritoneal) and Filtration Procedures in office or home setting, for acute or chronic renal failure - Includes administration and supplies.</td>
<td>80% of PA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Services – Other than Surgery or Maternity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Room and Board expense daily semi-private room rate and general nursing care provided by the Hospital. <strong>Note:</strong> Only one (1) Copayment amount, if any, for Room and Board, and Intensive Care Room applies to each admission for the same Condition.</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Intensive Care Room <strong>Note:</strong> Only one (1) Copayment amount, if any, for Room and Board, and Intensive Care Room applies to each admission for the same Condition.</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Physician visit, during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility.</td>
<td>80% of PA</td>
</tr>
<tr>
<td>Consulting Physician, when requested and approved by the Attending Physician.</td>
<td>80% of PA</td>
</tr>
<tr>
<td>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.</td>
<td>80% of PA</td>
</tr>
</tbody>
</table>
Inpatient Rehabilitation Facility
- Includes Physical Therapy, Occupational Therapy, Restorative Speech Therapy, Cardiac therapy, and Pulmonary Therapy.

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 50% of the Benefit otherwise payable for the secondary procedure and 25% of the Benefit otherwise payable for each subsequent procedure.

### Inpatient Surgical Services

<table>
<thead>
<tr>
<th>Procedure</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

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 | 60% of R&C

### Other Surgical Services (Inpatient/Outpatient)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Anesthesia for Dental services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

Major Oral or Dental procedures to prepare the jaw for radiation treatment of oral or throat cancers.

80% of PA | 60% of R&C

Obesity Surgery for the treatment of Morbid Obesity
- The Covered Person must complete pre-surgical education in order to qualify for benefits under this Policy. Limited to one (1) bariatric surgical procedure per lifetime.

80% of PA | 60% of R&C

Reconstructive Surgery - Includes Medically Necessary breast reduction and varicose vein removal; Post-mastectomy reconstruction of the impacted and non-impacted breast to achieve a symmetrical appearance.

80% of PA | 60% of R&C

Organ Transplant Surgery - Limited to heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas and autologous bone marrow transplants only.

80% of PA | 60% of R&C

Donor Services - Covered only for services not covered by the donor’s own plan. Excluded for a Covered Person donating to a recipient not covered by this Policy.

80% of PA | 60% of R&C

Reproductive Services

Voluntary Sterilization Surgery

**Note:** Sterilization procedures for women are covered under Preventive Care.

80% of PA | 60% of R&C

Elective Termination of Pregnancy

80% of PA | 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 exams, the first postnatal exam, routine tests and ultrasounds | 100% of PA Deductible & Copayments waived | 60% of R&C |
| Delivery and Inpatient Physician visits for mother and baby. | 80% of PA | 60% of R&C |
| Diagnostic services performed and billed by a Physician’s office, including diagnostic ultrasounds and amniocentesis. | 100% of PA after a $50 Copayment per visit + waiver of Deductible | 60% of R&C |

**Mental Illness and Substance Use Disorder (including Severe Mental Illness or Serious Emotional Disturbance of a Child – see State Mandates)**

| Inpatient services † including Alcoholism/Drug detoxification | 80% of PA | 60% of R&C |
| Outpatient Office Visits (Includes partial, residential or day treatment) | 100% of PA after a $50 Copayment per visit + waiver of Deductible | 60% of R&C |
| Other Outpatient treatment (anything outside of an Office Visit, Emergency Services or Prescription drugs) | 80% of PA | 60% of R&C |

**Urgent Care and Emergency Services**

| Urgent Care Facility (non-Emergency) services | 80% of PA | 60% of R&C |

**Emergency services** – visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition; Includes Physician’s fees, Diagnostic Imaging, Laboratory, Injections, use of emergency room, supplies, and facility charges. Including Emergency services for Mental Illness & Substance Use Disorder. Copayment waived if admitted to Hospital - Follow-up care at the Emergency room is not covered

| 80% of PA after a $100 Copayment per visit | 80% of PA after a $100 Copayment per visit |

Emergency Medical Transportation Services (Including non-emergency licensed ambulance and psychiatric transport van services).

| 80% of R&C |

**Other Services**

<p>| Allergy Testing | 80% of PA | 60% of R&amp;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&amp;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&amp;C |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage of PA</th>
<th>Percentage of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Rehabilitative Care - only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, Occupational Therapy, and Restorative Speech Therapy; Outpatient Physical Therapy is limited to twelve (12) visits per Condition.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Pulmonary Therapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Cardiac Therapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Acupuncture - typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Dermatology (not including treatment of acne)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Podiatry</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Home Health Care services – no more than $500 Deductible for In-Network services will apply per Policy Year.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospice - Includes bereavement counseling and respite care.</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>Prosthetic and Orthotic Devices - Includes replacement, repair, fitting and adjustment.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Formulas and Low Protein Modified Foods - prescribed Enteral formulas and services and supplies provided to Covered Persons suffering from an inherited metabolic disorder (such as PKU).</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>TMJ – treatment for the dysfunction of the temporomandibular joints, including surgical treatment of the jaw, to correct or treat TMJ.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hearing Screenings for Covered Persons nineteen (19) years of age and older (under age nineteen (19) covered under Preventive Services).</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Specialty Lenses – special contact lenses for aniridia when prescribed by an optometrist or other Physician are limited to two (2) Medically Necessary contact lenses per eye (including fitting and dispensing) in any Policy Year to treat aniridia; and up to six (6) Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per Policy Year to treat aphakia for Covered Persons through age nine (9).</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Elective Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental treatment due to Injury to a Sound Natural Tooth</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Repair or replacement of eye glasses, contact lenses or hearing aids when required as a direct result of an Injury.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Non-emergency out-of-country, if not covered by any other coverage.</td>
<td></td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Evacuation Services</td>
<td>100% of charges</td>
<td></td>
</tr>
<tr>
<td>Repatriation Services</td>
<td>100% of charges</td>
<td></td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment Benefit Amount</td>
<td>$5,000</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Coverage Percentage</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Pediatric Dental – preventive & diagnostic services, for Covered Persons under age 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 24 months  
  - sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months)  
  - space maintainers, including removable acrylic and fixed band type | 100% of R&C |
| Pediatric Dental – basic restorative services, for Covered Persons under age nineteen (19); Includes:  
  - emergency palliative treatment of pain  
  - fillings (amalgam, resin-based composite, acrylic, synthetic or plastic) including Medically Necessary replacement  
  - endodontics - pulpotomy or vital pulpotomy  
  - periodontics - scaling and root planning and subgingival curettage, limited to five (5) quadrant treatments every 12 months  
  - prosthodontics – acrylic and prefabricated stainless steel crowns; denture and crown repair, denture rebase/reline (1 per arch every 12 months) recementation of crowns, bridges, inlays and onlays; replacement of crowns and dentures (1 per 36 months unless Medically Necessary) | 70% of R&C |
| Pediatric Dental – major services, for Covered Persons under age nineteen (19); Includes:  
  - prosthodontics - crowns, bridges, and dentures  
  - endodontics  
  - periodontics – gingivectomy; osseous or muco-gingival surgery; emergency treatment, including treatment for periodontal abscess and acute periodontitis  
  - general anesthesia and IV sedation – in conjunction with complex oral surgery  
  - analgesia (nitrous oxide) or non-IV sedation (not in conjunction with general anesthesia or IV sedation) | 50% of R&C |
| Pediatric Dental – Medically Necessary orthodontia services*, for Covered Persons under age nineteen (19). Includes:  
  - pre-orthodontic treatment  
  - orthodontic treatment  
  - appliance therapy  
  - orthodontic retention  
  Subject to 12-month waiting period for services  
*Requires pre-authorization | 50% of R&C |
Routine Vision Exam for Covered Persons under age 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
- 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. Low vision aid devices are limited to one (1) per year.

### Outpatient Prescription Drugs

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

The Pharmacy Benefits Manager (PBM) is: Cigna at www.cigna.com

**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.

<table>
<thead>
<tr>
<th>3 Tier Plan</th>
<th>In-Network Pharmacy Benefit: 100% after</th>
<th>Out-of-Network Pharmacy Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Generic Drugs</td>
<td>$15 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>2. Preferred Brand Drugs</td>
<td>$35 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>3. Non-Preferred Brand and Specialty Drugs</td>
<td>$70 Copayment</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

You must show Your Identification Card to the pharmacist. Normally there are no claims to file. If You forget Your Identification Card, You may be asked 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);

### Mail Service Prescription Drugs - per prescription or refill, (In-Network Benefit only)

<table>
<thead>
<tr>
<th>3 Tier Plan</th>
<th>Participating Pharmacy Benefit: 100% after</th>
<th>Non-Participating Pharmacy Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>One (1) Copayment per thirty (30) day supply.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- No cost sharing applies to Generic Contraceptives or other Preventive Services drugs; Includes FDA approved prescription and over-the-counter contraceptives and contraceptive devices for women, preventive over-the-counter drugs when prescribed by a Physician on the USPSTF A&B recommendations list, and FDA approved smoking deterrent prescription and over-the-counter medications for a 90-day treatment regimen when prescribed by a Provider;
- Sexual enhancement drugs are limited to a maximum of 8 doses in any 30-day period or 27 doses in any 100-day period;
- Includes medications, equipment and supplies for the management and treatment of diabetes;
- The Deductible does not apply;
- The Covered Person will be responsible for the cost difference between Brand and Generic, in addition to 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.
- Cost sharing for oral anticancer medication will be capped at $200 per 30-day supply.
- Coverage will include Medically Necessary disposable devices for administering a covered outpatient Prescription Drug, such as spacers and inhalers for aerosol drugs and syringes for drugs that are not dispensed in pre-filled syringes.
- Coverage is provided for appropriately prescribed pain management medications for terminally ill patients when Medically Necessary.
- For coverage of drugs that are not included on the formulary drug list, You may contact Cigna at www.cigna.com or call CHP at 800.633.7867 to determine if the benefits are available. For non-urgent cases, the PBM must provide its determination within seventy-two (72) hours of receipt of Your exception review request. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the PBM must provide its determination within twenty-four (24) hours of receipt of Your exception review request.
## MANDATED BENEFITS

If You are enrolled in this Insurance Program, Policy coverage also includes the following benefits, all subject to the Policy Aggregate Limit, unless provided otherwise, and is subject to Policy Deductibles, limitations and exclusions where applicable.

(Note: Wellness/preventive benefits under the Affordable Care Act (ACA) are required to meet federal regulations. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate. Please see the Schedule of Benefits for coverage details.)

- Acupuncture
- AIDS Vaccine
- Alcoholics Treatment
- Alpha Feto Protein Program
- Alzheimer’s Disease
- Behavioral Health Treatment for Pervasive Development Disorder or Autism
- Breast Cancer Screening, Diagnosis and Treatment
- Blood Lead Level Screening
- Cancer Clinical Trials
- Cancer Screening
- Cervical Cancer Screening
- Diabetes, Diethylstilbestrol (DES) Exposure
- General Anesthesia for Dental Procedures
- HIV Testing
- Home Health Care
- Infertility
- Jawbone Surgery
- Laryngectomy (Prosthetics)
- Mammography
- Mastectomy and Reconstructive Surgery
- Nicotine Treatment
- Off-Label Prescription Drug Use
- Oral Cancer Medication
- Orthotic and Prosthetic Devices and Services
- Osteoporosis
- Phenylketonuria
- Prenatal Diagnosis of Genetic Disorders of the Fetus
- Prostate Cancer Screening
- Reconstructive Surgery
- Second Opinion
- Severe Mental Illness and Serious Emotional Disturbance of a Child
- Special Footwear for Persons Suffering from Foot Disfigurement
- Transplantation Services for Persons with HIV

## PREferred PROVIDER INFORMATION

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

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.

If care is received within the Network from a Preferred Provider, all Covered Medical Expenses will be paid at the Preferred Provider level of benefits found on the Schedule of Benefits.

In the case of an Emergency, if an Out-of-Network Provider is used, the In-Network percentage in the Schedule of Benefits will be applied.

A Covered Person is not required to seek treatment from a Preferred Provider. Each Covered Person is free to elect the services of a Provider and Benefits payable will be made in accordance with the terms and Conditions of this benefit.

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

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

## COORDINATION OF BENEFITS

The Policy Year is the basis for consideration of claims. This provision will be used when the Benefits the Covered Person would receive under this Policy plus those received under all other Plans would exceed the total Allowable expense. If the Benefits provided under all Plans exceed the Allowable expense, We will reduce Our Benefits so that the total benefit received from all plans does not exceed 100% of Allowable expenses. When Benefits are reduced under the primary plan because the Covered Person did not comply with the plan provisions, the amount of such reduction will not be considered an Allowable expense.

## SUBROGATION AND RECOVERY RIGHTS

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

**EXCLUSIONS**

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

1. Eyeglasses, contact lenses, routine eye refractions, eye examinations except as in the case of Injury or as provided. Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.

2. Hearing aids and the fitting or repairing or replacement of hearing aids, except in the case of Accident or Injury.

3. Vaccines and immunizations (except as specifically provided in the Policy): a) required for travel; and b) required for employment.

4. Treatment (other than surgery) of chronic Conditions 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, any type of massage procedure on or to the foot, corrective shoes, shoe inserts and Orthotic Devices, 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 except as provided herein or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; 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). This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, injury, infection or other disease 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.

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

9. Custodial Care, long term care provided in a: rest home, home for the aged, halfway house, health resort, college infirmary or any similar facility for domiciliary or Custodial Care, or that provides twenty-four (24) hour non-medical residential care or day care (except as provided for Hospice care).

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

11. Reproductive/Infertility services including but not limited to: 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 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.

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

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

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

15. Services received before the Covered Person’s Effective Date; Services received after the Covered Person’s Coverage ends, except as specifically provided under the Extension of Benefits provision.

16. Under the Prescription Drug Benefit, any drug or medicine:
   - Obtainable Over the Counter (OTC), except as specifically provided under Preventive Care;
   - for the treatment of alopecia (hair loss) or hirsutism (hair removal);
   - for the purpose of weight control;
   - anabolic steroids used for body building;
   - for the treatment of infertility;
   - cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or
treatment of acne, except as specifically provided in this Policy;
- treatment of nail (toe or finger) fungus;
- refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
- for an amount that exceeds a 30 day supply;
- drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
- purchased after Coverage under the Policy terminates;
- consumed or administered at the place where it is dispensed;
- if the FDA determines that the drug is:
  - contraindicated for the treatment of the Condition for which the drug was prescribed;
  - or Experimental for any reason.
17. Services for the treatment of any Injury or Sickness incurred while committing or attempting to commit a felony.
18. War or any act of war, declared or undeclared; or while on active duty in the armed forces of any country.
19. Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations.
20. Nutrition counseling services (except as specifically provided in the Policy), including services by a Physician for general nutrition, weight increase or reduction services, except as specifically provided in the Policy; general fitness, exercise programs, health club memberships and weight management programs; exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment; any equipment obtainable without a Physician’s prescription.
21. Treatment received outside of the United States of American, except when Medically Necessary for an Emergency or as specified herein.
22. Non-cystic acne.
23. Acupressure, aroma therapy, hypnosis, rolfing, Hyperhidrosis, Psychosurgery, biofeedback.
24. Elective treatment, except as specified in the Schedule of Benefits.

DEFINITIONS

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

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

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

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

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

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

Brand Name Prescription Drugs: Drugs for which the drug manufacturer’s trademark registration is still valid, and who’s trademarked or proprietary name of the drug still appears on the package label. See also Preferred Brand Drug and Non-Preferred Brand Drug.

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

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

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

Copayment: A specified dollar amount a Covered Person must pay for specified Covered Charges. The Copayment is separate from and not 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 in the Schedule of Benefits, as applicable.

Emergency: A 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 (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

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. For further explanation, see of Medically Necessary/Medical Necessity provision.

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.

Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychiatric disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

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

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

Injury: Bodily Injury due to a specific, sudden, unforeseeable, external event. 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: 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.

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

Covered Services are Medically Necessary if they are:

- Required to meet the health care needs of the Covered Person; and
- Consistent (in scope, duration, intensity and frequency of treatment) with current scientifically based guidelines of national medical or research organizations or governmental agencies; and
- Consistent with the diagnosis of the Condition; and
- Required for reasons other than the comfort or convenience of the Covered Person or Provider; and
- Of demonstrated medical value and medical effectiveness.
A Covered Service is Medically Appropriate if it is rendered in the most cost-effective manner and type of setting appropriate for the care and treatment of the Condition.

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

Mental Illness: A Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Expense.

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: means the most You will pay during a Policy Year before your coverage pays at 100% of the allowed amount. This limit will never include Premium, balance-billed charges or Health care Your Policy does not cover. Your other non-covered expenses and Elective Treatment do not count toward this limit.

Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:

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

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

Policy Year: The period of twelve (12) months following the Policy’s Effective Date.

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

Pre-admission Testing: Tests done in conjunction with a scheduled surgery where an operating room has been reserved before the tests are done.

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

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

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

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

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 90th 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.
**Telemedicine**: The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Neither a telephone conversation nor an electronic mail message between a Physician and patient constitutes “Telemedicine”.

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

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

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

**We, Our and Us**: Nationwide Life Insurance Company.

**You and Your**: The Covered Person or Eligible Person as applicable. Male pronouns whenever used include female pronouns.

### ACCIDENTAL DEATH AND DISMEMBERMENT

If the Eligible Person, within 180 days from the date of an Accident which occurs while Coverage is in force dies as the result of an Injury from such Accident, We will pay the Eligible Person’s beneficiary the amount for loss of life as shown in the Schedule of Benefits. If the Eligible Person, within 180 days from the date of an Accident, which occurs while Coverage is in force, suffers dismemberment as the result of Injury from such Accident, We will pay the Eligible Person the amount set opposite such loss, as shown on the Schedule of Benefits. If more than one (1) such loss is sustained as the result of one (1) Accident, We will pay only one (1) amount, the largest to which the Eligible Person or his or her beneficiary would be entitled.

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

<table>
<thead>
<tr>
<th>Loss of Life:</th>
<th>Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$5,000</td>
</tr>
<tr>
<td>Two hands or two feet</td>
<td>$5,000</td>
</tr>
<tr>
<td>Sight of two eyes</td>
<td>$5,000</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>$2,500</td>
</tr>
<tr>
<td>One hand and sight of one eye</td>
<td>$2,500</td>
</tr>
<tr>
<td>One foot and sight of one eye</td>
<td>$2,500</td>
</tr>
<tr>
<td>One hand or one foot or one eye</td>
<td>$2,500</td>
</tr>
<tr>
<td>Thumb or index finger</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

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

Loss of sight must be entire and irrecoverable. Loss of a thumb and index fingers means loss by severance at or above the metacarpophalangeal joints, which are the joints between the fingers and the hand.

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

### MEDICAL EVACUATION BENEFIT

If the Insured cannot continue their academic program because they sustain 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 their current place of primary residence or outside of their 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. Before We make any payment, We require written certification by the Attending Physician that the evacuation is necessary. Any expense for medical evacuation requires Our prior approval and coordination. For international students, once evacuation is made outside the country, Coverage terminates. This Benefit does not include the transportation expense of anyone accompanying the Covered Person or visitation expenses.

### REPATRIATION OF REMAINS BENEFIT

If the Covered Person dies while Insured under the Policy and is more than 100 miles from their permanent residence or outside of their Home Country, We will pay for the actual charge incurred for embalming, and/or cremation and returning the body to their place of permanent residence in their 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.

### CLAIM PROCEDURES

In the event of Injury or Sickness, students should:

1. Report to their Physician, Hospital or Student Health Center.
2. Mail to the address below all medical and hospital bills along with the patient’s name and insured student’s name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within ninety (90) days of Injury or first treatment for a Sickness. Bills should be received by the Company within ninety (90) days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.
4. Itemized medical bills should be mailed promptly to Cigna at the address listed.

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

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

CLAIMS ADMINISTRATOR:
Consolidated Health Plans
2077 Roosevelt Ave
Springfield, MA 01104
Local: (413) 733-4540 or Out of area: (800) 633-7867
www.chpstudent.com
Group Number: S211715

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

Claims Administrator:
CONSORTIUM HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
www.chpstudent.com
(413) 733-4540

Servicing Agent:
Cypress Risk Management
1601 E 69th St, Suite 209
Sioux Falls, SD 57108
(855) 504-6445

This plan is underwritten by and offered by:
NATIONWIDE LIFE INSURANCE COMPANY
Columbus, OH
Policy Number: 302-900-0414

For a copy of the privacy notice you may go to:
www.consolidatedhealthplan.com/about/hipaa

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.

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

NO-COST LANGUAGE ASSISTANCE SERVICES
You can get an interpreter and have documents read to you in your language.
For help, call the number listed on your insurance ID card: **1-800-633-7867.** For
more help, call the CA Department of Insurance at **1-800-927-4357.**