

Student Health Insurance Plan Designed for the Students of



2016-2017

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH

Policy Number: 302-004-1214

Group Number: S215016

Effective: 8/1/2016 to 7/31/2017

Administered by:



Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

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WHERE TO FIND HELP

For Questions About:	Please Contact or visit:
Enrolling in the insurance plan	www.greenvilleship.com
Insurance Benefits	Associated Insurance Plans International, Inc. 609 N. Pine Street, Suite 202 Burlington, WI 53105 (800) 452-5772 www.greenvilleship.com
Insurance Benefits Preferred Provider Listings Claims Processing Id Card Requests	Consolidated Health Plans 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 www.chpstudent.com
Preferred Provider Listings	Consolidated Health Plans or First Health PPO www.firsthealth.com (800) 226-5116

AM I ELIGIBLE?

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

Any Insured voluntarily withdrawing from school during the first thirty-one (31) days of the period for which Coverage is purchased, will not be covered under this Policy and a full refund of Premium will be made minus the cost of any claim Benefits made by Us. Insureds withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed except as otherwise specified herein.

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

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

CREDIT HOUR REQUIREMENTS

All full time undergraduate students taking 12 or more credit hours per semester are required to have insurance coverage. You must enroll in this plan or provide evidence of other comparable coverage to the College by deadline date below.

Graduate students are eligible to enroll in this insurance plan on a voluntary basis by the deadline dates below.

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

HOW DO I WAIVE/ENROLL?

All full time undergraduate students taking 12 or more credit hours per semester are required to have insurance coverage. You must enroll in this plan or provide evidence of other comparable coverage to the College by deadline date below. You may do so by visiting www.greenvilleship.com.

Graduate students are eligible to enroll in this insurance plan on a voluntary basis by the deadline date below.

2016/2017 Enrollment or Waiver Deadlines Dates:

Annual/Fall Semester: September 7, 2016

Spring/Summer Semester: February 5, 2017

INVOLUNTARY LOSS OF OTHER COVERAGE

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

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

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

EFFECTIVE DATES AND COSTS

	Annual*	Fall**	Spring*
	8/1/2016 - 7/31/2017	8/1/2016 - 1/4/2017	1/5/2017 - 7/31/2017
Student	\$1,180	\$507	\$673

**The above rates include an administrative fee.*

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

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the Covered Person's Termination Date. However, if a Covered Person is: Hospital Confined 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. Totally Disabled on the Termination Date from a covered Injury or Sickness for which Benefits were paid before the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of fifty-two (52) weeks or until the date the disability ends, whichever is earlier.

Totally Disabled means:

- With respect to the Insured, the inability to attend classes at the location where he is enrolled;
- With respect to a Dependent, or the Insured, if such classes are not in session, disability means the inability to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the Covered Person immediately prior to the Injury or Sickness; and
- Under the care of a Physician for period of Total Disability

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.

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 independent of disease or bodily infirmity, results in an Injury.

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

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

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

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

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

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

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

Civil Union: Means a legal relationship between two persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Clinical Trials

We provide Coverage for participation of a Qualified Individual in an Approved Clinical Trial. This includes the routine patient costs for items and services furnished in connection with participation in the Approved Clinical Trial.

"Approved Clinical Trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a Life-threatening Condition (including Cancer) and is described in any of the following:

- (A) The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:
- (i) The federal National Institutes of Health;
 - (ii) The federal Centers for Disease Control and Prevention;
 - (iii) The federal Agency for Health Care Research and Quality;
 - (iv) The federal Centers for Medicare & Medicaid Services;
 - (v) A cooperative group or center of any of the entities described in items (i) through (iv) or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;
 - (vi) A qualified non-governmental research entity identified in the guidelines issued by the federal National Institutes of Health for center support grants; or
 - (vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:
 - (I) Is comparable to the system of peer review of studies and investigations used by the federal National Institutes of Health; and
 - (II) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- (B) The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration; or
- (C) The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

"Qualified Individual" means a participant or Beneficiary who meets the following conditions:

- (A) The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or Condition; and
- (B)
 - i. The referring health care professional is a participating Provider and has concluded that the individual's participation in such trial would be appropriate based on the individual meeting the conditions; or
 - ii. The participant or Beneficiary provides medical and scientific information establishing the individual's participation in such trial would be appropriate based on the individual meeting the conditions.

"Life-threatening Condition" means any disease or Condition from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.

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

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

Complications of Pregnancy: A Condition which:

- When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) preeclampsia/eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; (i) and other similar medical and surgical Conditions of comparable severity related to pregnancy; (j) hyperemesis gravidarum; or
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will **not** include:

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

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

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

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

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

Covered Charge(s) or Covered Expense: As used herein means those charges for any treatment, services or supplies:

- For Preferred Providers, not in excess of the Preferred Allowance;
- For Out-of-Network Providers not in excess of the Reasonable and Customary expense; and
- Not in excess of the charges that would have been made in the absence of this insurance; and
- Not otherwise excluded under this Policy; and
- Incurred while this Policy is in force as to the Covered Person

Covered Person: A person:

- Who is eligible for Coverage as the Insured;
- 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.

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

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

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

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

Durable Medical Equipment: A device which:

- Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
- Is used exclusively by the patient;
- Is routinely used in a Hospital but can be used effectively in a non-medical facility;
- Can be expected to make a meaningful contribution to treating the patient's Sickness or Injury; and
- Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.

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

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

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

Eligible Person: The person who meets the eligibility criteria of the Policyholder.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) 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;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

Emergency Medical Condition 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.

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

Charges are payable only for transportation from the site of an Emergency Medical Condition to the nearest available Hospital that is equipped to treat the Condition.

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; Drugs; Rehabilitative and Habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

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

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

Experimental/Investigational: The service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see of Medically Necessary/Medical Necessity provision.

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

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

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

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

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

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

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

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

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

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

Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

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

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

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

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

Illness: Sickness or disease.

Infection: Bacterial infections, except infections which result from an Accidental Injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance.

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

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

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

Injury: Bodily Injury due to a sudden, unforeseeable, external event which results independently of disease or bodily infirmity. All injuries sustained in any one (1) Accident, including all related conditions and recurrent symptoms of these injuries, and are considered a single Injury.

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

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

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

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

Intoxication: Means that which is defined and determined by the laws of the jurisdiction where the loss or cause of the loss was incurred.

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

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

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

Medical Literature:

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

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

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

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

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

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

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

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

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

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

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

Physical Therapy: Any form of the following: Physical or mechanical therapy; Diathermy; Ultra-sonic therapy; Heat treatment in any form; or Manipulation or massage.

"Preventative Physical Therapy" means Physical Therapy that is prescribed by a Physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the Physical Therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

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.

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

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

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

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

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

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

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

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

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

1. Approved for general use by the U.S. Food and Drug Administration (FDA); and
2. Prescribed by a licensed Physician for the treatment of a Life-Threatening Condition, or prescribed by a licensed Physician for the treatment of a Chronic and Seriously Debilitating Condition, the drug is Medically Necessary to treat that Condition, and the drug is on the Formulary, if any; and
3. The drug has been recognized for treatment of that Condition by one of the Standard Medical Reference Compendia or in the Medical Literature as recommended by current American Medical Association (AMA) policies, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Condition. The Drugs must be dispensed by a licensed pharmacy Provider for out of Hospital use, except as specifically provided under Preventive Care. Prescription Drug Coverage shall also include Medically Necessary supplies associated with the administration of the drug.

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

- (a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer

screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

Covered Services include but are not limited to:

1. **Abdominal Aortic Aneurysm one-time screening** for men of specified ages who have never smoked
 2. **Alcohol Misuse screening and counseling**
 3. **Aspirin use** to prevent cardiovascular disease for men and women of certain ages
 4. **Blood Pressure screening** for all adults
 5. **Cardiovascular disease** for adults, early detection and proactive management
 6. **Cholesterol screening** for adults of certain ages or at higher risk
 7. **Colorectal Cancer screening** - for adults over age 50; all colorectal cancer exams and lab tests for colorectal cancer as prescribed by Physician according to American Cancer Society.
 8. **Depression screening** for adults
 9. **Diabetes (Type 2) screening** for adults with high blood pressure
 10. **Diet counseling** for adults at higher risk for chronic disease
 11. **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
 12. **Immunization vaccines** for adults--doses, recommended ages, and recommended populations vary:
 - a. Hepatitis A
 - b. Hepatitis B
 - c. Herpes Zoster
 - d. Human Papillomavirus
 - e. Influenza (Flu Shot)
 - f. Measles, Mumps, Rubella
 - g. Meningococcal
 - h. Pneumococcal
 - i. Tetanus, Diphtheria, Pertussis
 - j. Varicella
 13. **Obesity screening and counseling** for all adults
 14. **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
 15. **Syphilis screening** for all adults at higher risk
 16. **Tobacco Use screening** for all adults and cessation interventions for tobacco users.
- (b) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(c) With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; Covered services include but are not limited to:

1. **Autism screening** for children at 18 and 24 months
2. **Behavioral assessments** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
3. **Blood Pressure screening** for children at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. **Cervical Dysplasia screening** for sexually active females
5. **Depression screening** for adolescents
6. **Developmental screening** for children under age 3
7. **Dyslipidemia screening** for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
8. **Fluoride Chemoprevention supplements** for children without fluoride in their water source
9. **Gonorrhea preventive medication** for the eyes of all newborns
10. **Hearing screening** for all newborns
11. **Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
12. **Hematocrit or Hemoglobin screening** for children
13. **Hemoglobinopathies or sickle cell screening** for newborns
14. **HIV screening** for adolescents at higher risk
15. Hypothyroidism screening for newborns
16. **Immunization vaccines** for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella
17. **Iron supplements** for children ages 6 to 12 months at risk for anemia
18. **Lead screening** for children at risk of exposure

19. **Medical History** for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years.
20. **Obesity screening and counseling**
21. **Oral Health risk assessment** for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
22. **Phenylketonuria (PKU) screening** for this genetic disorder in newborns
23. **Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk
24. **Tuberculin testing** for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
25. **Vision screening** for all children

(d) With respect to women (including pregnant 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.

Covered services include but are not limited to:

1. **Anemia screening** on a routine basis for pregnant women
2. **Breast Cancer Genetic Test Counseling (BRCA)** for women at higher risk for breast cancer
3. **Breast Cancer Mammography screenings**
 - Coverage of screening by low-dose mammography for all women over 35; Coverage requires baseline mammogram for women 35-39 and annual mammogram for women 40 years of age and older.
 - For women under 40 with a family history of breast cancer or other risk factors mammograms must be provided at an age and intervals considered Medically Necessary.
 - Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates Medical Necessity as described.
 - Coverage must be provided at no cost to the Insured and shall not be applied to an annual or lifetime maximum benefit.

When coverage is available through contracted providers and such a provider is not utilized, plan provisions specific to the use of those non-contracted providers must be applied without distinction to the coverage required and shall be at least as favorable as for other radiological examinations covered by the Policy or contract.

4. **Breast Cancer Chemoprevention counseling** for women at higher risk
5. **Breastfeeding comprehensive support and counseling** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women

6. **Cervical Cancer screening** for sexually active women
7. **Chlamydia Infection screening** for younger women and other women at higher risk
8. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt “religious employers.”
9. **Domestic and interpersonal violence screening and counseling** for all women
10. **Folic Acid** supplements for women who may become pregnant
11. **Gestational diabetes screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. **Gonorrhea screening** for all women at higher risk
13. **Hepatitis B screening** for pregnant women at their first prenatal visit
14. **HIV screening and counseling** for sexually active women
15. **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older
16. **Osteoporosis screening** for women over age 60 depending on risk factors
17. **Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
18. **Sexually Transmitted Infections counseling** for sexually active women
19. **Syphilis screening** for all pregnant women or other women at increased risk
20. **Tobacco Use screening and interventions** for all women, and expanded counseling for pregnant tobacco users
21. **Urinary tract or other infection screening** for pregnant women
22. **Well-woman visits** to get recommended services for women under sixty-five (65); including but not limited to clinical breast exams, pap tests and pelvic exams.

The Illinois guidelines for frequency of breast exams is:

- At a minimum every three (3) years for women over twenty (20) years of age but less than forty (40); and,
- Annually for women forty (40) years of age and older.

Pap tests includes annual cervical smear or Pap smear, including surveillance tests for ovarian cancer for female Insureds who are at risk for ovarian cancer.

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

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

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

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

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

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

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

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

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

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

Sickness: Illness, disease or Condition, including pregnancy and Complications of Pregnancy, that impairs a Covered Person’s normal functioning of mind or body and which is not the direct result of an Injury or Accident. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

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

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

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

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

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

Standard Medical Reference Compendia: The following publications:

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

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

Surgeon: A Physician who actually performs surgical procedures.

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

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

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

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

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

We, Our and Us: Nationwide Life Insurance Company.

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

Male pronouns whenever used include female pronouns.

PREFERRED PROVIDER INFORMATION

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

SCHEDULE OF BENEFITS

Actuarial Value: 81.37%

Equivalent or next lowest coverage level: Gold

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

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

EFFECTIVE DATE: 8/1/2016

TERMINATION DATE: 7/31/2017

Policy Year Maximum Benefit		
Insured	unlimited	
	In-Network Benefit	Out-of-Network Benefit
Deductible (except as specified herein) per Policy Year per Covered Person; Benefits are subject to Deductible unless otherwise indicated. <ul style="list-style-type: none"> The Deductible shall not apply: <ul style="list-style-type: none"> In-Network Preventive/wellness exams and immunizations; To Outpatient Prescription Drugs from a Participating Pharmacy; Copayments do not apply to Deductibles. 	\$200	\$400

Insured Percent (except as specified herein)	80% of the Preferred Allowance (PA)	60% of the Reasonable and Customary Charges (R&C)
Out-of-Pocket Maximum per Covered Person <ul style="list-style-type: none"> Includes Coinsurance, Copayments and Deductibles; Excludes non-covered medical expenses and Elective Treatment; Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year; Once the In-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network. Once the Out-of-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% Out-of-Network. 	\$6,350	\$19,050
Covered Charges for Essential Health Benefits	In-Network Benefit	Out-of-Network Benefit
Preventive Care (See Definition and page 20 for additional information.)		
Preventive Services	100% of PA Deductible waived	60% of R&C

Outpatient Services - Other than Surgery or Maternity Services		
Office visits performed and billed by a Physician's office, including Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician. <ul style="list-style-type: none"> Limited to one (1) visit per day; Does not apply when related to surgery. Includes Consulting Physician / Specialists. 	80% of PA after a \$20 Copayment per visit	60% of R&C after a \$20 Copayment per visit
Diagnostic Imaging - Includes x-ray services which are diagnostic or therapeutic.	80% of PA	60% of R&C
Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.	80% of PA	60% of R&C
Bone Density Testing - Covered only for the measurement, diagnosis and treatment of osteoporosis.	80% of PA	60% of R&C
Blood and Blood Components	80% of PA	60% of R&C
CT Scan, MRI, and /or PET Scans	80% of PA	60% of R&C
Infusions (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	60% of R&C
Injections (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	60% of R&C
Radiation	80% of PA	60% of R&C
Chemotherapy	80% of PA	60% of R&C
Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - Includes administration and supplies.	80% of PA	60% of R&C

Inpatient Services – Other than Surgery or Maternity Services		
Miscellaneous Hospital Services - Includes meals and prescribed diets, Diagnostic Imaging, Laboratory, pharmaceuticals administered while an Inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical event, Pre-Admission Testing and Inpatient Rehabilitation	80% of PA	60% of R&C
Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital.	80% of PA	60% of R&C
Intensive Care Room	80% of PA	60% of R&C
Physician visit, during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility. <ul style="list-style-type: none"> Does not apply when related to surgery. Includes Consulting Physician / Specialists. 	80% of PA	60% of R&C
Skilled Nursing Facility and Sub-Acute Care Facility - Includes semi-private room and board, general nursing services, meals and prescribed diets, supplies, Diagnostic Imaging, laboratory, Rehabilitation.	80% of PA	60% of R&C

Inpatient Rehabilitation Facility - Includes Physical Therapy, Occupational Therapy, Restorative Speech Therapy, Cardiac therapy, and Pulmonary Therapy which is expected to result in significant return of function.	80% of PA	60% of R&C
Surgical Services		
When multiple surgeries are performed through the same incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed.		
When multiple surgeries are performed through more than one (1) incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. The Benefit for the primary or most expensive procedure or less expensive procedure is 50% of the Benefit otherwise payable for each subsequent procedure.		
Inpatient Surgical Services		
Surgeon Additional Surgical Opinion - Following a recommendation for an Elective Surgery. Covered at 100% of claim charge for one (1) consultation and related diagnostic service by a Physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in Your opinion, is not resolved by the first consultation.	80% of PA	60% of R&C
Assistant Surgeon	80% of PA	60% of R&C
Anesthetist Services	80% of PA	60% of R&C

Inpatient Surgical Miscellaneous - Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	80% of PA	60% of R&C
Outpatient Surgical Services		
Surgeon Additional Surgical Opinion - Following a recommendation for an Elective Surgery. Covered at 100% of claim charge for one (1) consultation and related diagnostic service by a Physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in Your opinion, is not resolved by the first consultation.	80% of PA	60% of R&C
Assistant Surgeon	80% of PA	60% of R&C
Anesthetist Services	80% of PA	60% of R&C
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)		
General Anesthesia for Dental services	80% of PA	60% of R&C
Reconstructive Surgery - Includes coverage for the correction of congenital deformities or for conditions resulting from accidental injuries, scars tumors or disease, including after mastectomy.	80% of PA	60% of R&C

<p>Organ Transplant Surgery - Coverage provided for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas and pancreas/kidney organ or tissue transplants.</p> <p>Note: No Accident and Health Insurer may deny reimbursement for an organ transplant as Experimental or Investigational unless supported by appropriate, required documentation.</p> <p>Benefits are available to both the recipient and donor of a covered transplant as follows:</p> <ul style="list-style-type: none"> • If both the donor and recipient have coverage provided by the same Insurer each will have their benefits paid by their own program. • If You are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Policy will be provided for both You and the donor. In this case, payments made for the donor will be charged against Your benefits. • If You are the donor for the transplant and no coverage is available to You from any other source, the benefits under this Policy will be provided for You. However, no benefits will be provided for the recipient. 	80% of PA	60% of R&C
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<p>Benefits will be provided for:</p> <ul style="list-style-type: none"> • Inpatient and Outpatient Covered Services related to the transplant Surgery. • The evaluation, preparation and delivery of the donor organ. • The removal of the organ from the donor. • The transportation of the donor organ to the location of the transplant Surgery. <p>Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at in-network approved Human Organ Transplant Coverage Program.</p>		
<p>Organ Transplant Travel</p> <p>When transplant Hospital is located more than fifty (50) miles from the recipient's residence, coverage includes transportation and lodging for the recipient and up to five (5) Family Members, for a single round trip, with a single hotel room, totaling forty-five (45) days. Excludes coverage for meals.</p>	80% of PA	60% of R&C
<p>Bariatric Surgery when Medically Necessary to treat Morbid Obesity - Limited to one (1) surgical procedure per Lifetime.</p>	80% of PA	60% of R&C
Reproductive Services		
<p>Infertility Services – See additional Benefits sections for details</p>	80% of PA	60% of R&C
<p>Voluntary Sterilization Surgery</p> <p>Note: Sterilization procedures for women are covered under Preventive Care.</p>	80% of PA	60% of R&C

<p>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.</p>		
Outpatient Pre- and Post-Natal Care, except diagnostic services performed and billed by a Physician's office), delivery and Inpatient Physician visits for mother and baby.	Paid as any other Sickness	Paid as any other Sickness
Diagnostic services performed and billed by a Physician's office, including pre-natal HIV testing, ultrasounds and amniocentesis.	Paid as any other Sickness	Paid as any other Sickness
<p>Mental Conditions and Alcoholism/Drug Abuse</p>		
Inpatient services - including Alcoholism and Drug detoxification).	Paid as any other Sickness	Paid as any other Sickness
Outpatient Office Visits - Includes, but is not limited to, psychological testing, neuropsychological testing, electroconvulsive therapy, intensive outpatient programs, partial hospitalization treatment programs, if it is an in-network approved program. Includes partial, residential or day treatment.	Paid as any other Sickness	Paid as any other Sickness

Urgent Care and Emergency Services		
Urgent Care Facility services - Copayment waived if admitted to the Hospital	80% of PA after \$100 Copayment per visit	60% of R&C after \$100 Copayment per visit
Emergency services - visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition. Includes Physician's fees, Diagnostic Imaging, Laboratory, Injections, use of emergency room, supplies and facility charges. Follow-up care at the Emergency room is not covered. Note: The Copayment amount for this visit is waived if You are admitted to a Hospital	80% of PA after \$100 Copayment per visit	80% of R&C after \$100 Copayment per visit
Emergency Medical Transportation services - - including ground and air services. Services will not be provided for long distance trips solely because it is more convenient than other transportation.	80% of PA	80% of R&C
Other Services		
Allergy Testing	80% of PA	60% of R&C
Allergy Injections/treatment - Includes treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments. Also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.	80% of PA	60% of R&C

Clinical Trials - Includes coverage for routine patient costs associated with a Covered Person's participation in a clinical trial. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care of the Covered Person.	80% of PA	60% of R&C
Autism Spectrum Disorders - Includes psychiatric care and diagnostic services, psychological assessments and treatments, Habilitative or rehabilitative treatments, and therapeutic care.	80% of PA	60% of R&C
Habilitative Care - only when prescribed by the Attending Physician. Includes Outpatient Physical Therapy, Occupational Therapy, Inhalation Therapy, Cardiac Therapy, Pulmonary Therapy and Spinal Manipulation Therapy for a function that did not previously exist, but would normally be expected to exist. Coverage is provided only for Covered Persons aged eighteen (18) years or younger with congenital, genetic or early acquired disorders. Excludes services that are solely educational in nature.	80% of PA	60% of R&C
Physical Therapy - Outpatient - Includes preventive physical therapy for Covered Persons with Multiple Sclerosis.	80% of PA	60% of R&C
Speech Therapy	80% of PA	60% of R&C
Occupational Therapy	80% of PA	60% of R&C

Cardiac Therapy	80% of PA	60% of R&C
Pulmonary Therapy	80% of PA	60% of R&C
Respiratory Therapy	80% of PA	60% of R&C
Chiropractic care and Osteopathic Manipulation - Includes x-rays, office visits, laboratory services, massage therapy, manipulations and modalities (i.e., hot packs, cold packs and ultrasounds, etc.), regardless of Provider type.	80% of PA	60% of R&C
Dermatology	80% of PA	60% of R&C
Podiatry	80% of PA	60% of R&C
Home Health Care services You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and You must require Skilled Nursing Service on an intermittent basis under the direction of Your Physician. Includes: skilled nursing service by a registered professional nurse, services of physical, occupational and speech therapists, hospital laboratories, and necessary medical supplies. Services do not include and are not intended to provide benefits for Private Duty Nursing Care, or activities of daily living (such as personal hygiene, cleaning, cooking, etc.).	80% of PA	60% of R&C

Private Duty Nursing Care - Coverage is provided only for services that cannot be reasonably be self administered or provided by a Home Health Care agency.	80% of PA	60% of R&C
Hospice - Limited to Covered Persons with a life expectancy of one (1) year or less. Includes respite care for the Family Member primary care giver, coordinated home care, medical supplies and dressings, medication, skilled and non-skilled nursing services, occupational therapy, pain management services, physical therapy, Physician visits, and social and spiritual services.	80% of PA	60% of R&C
Diabetic treatment and education - Includes preventive and routine foot care.	80% of PA	60% of R&C
Durable Medical Equipment (DME) - Includes coverage for osseointegrated auditory implants and hearing aids for Covered Persons under the age of eighteen (18); Includes Prosthetic and Orthotic Devices.	80% of PA	60% of R&C

TMJ - treatment for the dysfunction of the temporomandibular joints, including surgery of the jaw to correct or treat TMJ; Coverage is limited to surgical removal of complete bony impacted teeth; excision of tumors and cysts; excision of exotoses of the jaw or hard palate; treatment of fractures of the facial bone; drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation or, or excision of, the temporomadibular joints. Any services related to preparation of the mouth for dentures are Not Covered.	80% of PA	60% of R&C
Dental treatment due to Injury to a Sound Natural Tooth not including damage caused by biting or chewing.	80% of PA	80% of R&C
Dietary Counseling - Includes healthy diet counseling and Obesity screening. Excludes weight loss programs, therapies, drugs and classes.	80% of PA	60% of R&C
Amino acid-based elemental formulas – includes reimbursement for amino acid-based elemental formulas, regardless of delivery method, for diagnosis and treatment of a Condition.	80% of PA	60% of R&C
Naprapathic Therapy	80% of PA	60% of R&C
Oxygen and its administration	80% of PA	80% of R&C
Shingles Vaccine - Coverage must include a vaccine for shingles that is approved by the federal Food and Drug Administration if it is ordered by a Physician for an Insured who is sixty (60) years of age or older.	80% of PA	60% of R&C

Pediatric Dental and Vision Services <i>for under the age of nineteen (19)</i> – Refer to the Pediatric Vision Services and Pediatric Dental Services provisions in the Policy and Certificate for additional details, including applicable limitations and exclusions.	
Pediatric Dental – preventive & diagnostic services; Limited to 1 exam / prophylaxis every 6 month. Includes: <ul style="list-style-type: none"> • topical fluoride treatment – 1 per 12 months • topical fluoride varnish – 1 per 12 months, ages 3+ (ages 0-2, 3 per 12 months) • x-rays – bitewing – 1 set per 12 months • x-rays - full-mouth and panoramic – 1 per 36 months • sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth per lifetime) • space maintainers - 1 per lifetime per quadrant/arch 	100% of R&C
Pediatric Dental – basic restorative services, Includes: <ul style="list-style-type: none"> • emergency palliative treatment of pain • fillings (amalgam, resin-based composite) - 1 per 12 months per tooth • pre-fabricated stainless steel crown - 1 per primary tooth per lifetime • other crowns - 1 per tooth every 60 months • endodontics - therapeutic pulpotomy • periodontics - scaling and root planning, limited to 1 every 24 months • prosthodontics – denture repair, denture rebase/reline (1 per 24 months; 6 months after initial installation) • simple extractions 	70% of R&C
Pediatric Dental – major services. Includes: <ul style="list-style-type: none"> • prosthodontics - bridges and dentures - 1 per tooth/arch every 60 months • endodontics (root canals on permanent teeth limited to one per tooth per lifetime) • periodontics – gingivectomy or gingivoplasty, limited to 1 every 36 months; full mouth debridement, limited to 1 per 6 months in office setting • oral surgery • general anesthesia, IV conscious sedation and non-IV conscious sedation – only in conjunction with complex oral surgery • analgesia 	50% of R&C

Pediatric Dental – Medically Necessary orthodontia services *, for Covered Persons under the age of nineteen (19) with severe and handicapping malocclusion. Includes: <ul style="list-style-type: none"> • pre-orthodontic treatment - 1 per lifetime • orthodontic treatment - 1 visit per 45 days • appliance therapy • orthodontic retention - 1 per lifetime *Requires pre-authorization & Subject to 12-month waiting period for services.	50% of R&C	
Routine Vision Exam. Includes: <ul style="list-style-type: none"> • 1 exam/fitting per Policy Year, including dilation if professionally indicated • prescription eyeglasses (lenses and frames), or one (1) year supply of contact lens in lieu of eyeglasses, limited to once per Policy Year • Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes. 	100% of charges up to \$150, then 50% thereafter	
Outpatient Prescription Drugs		
The Pharmacy Benefits Manager (PBM) is: OptumRx.		
Retail Prescription Drugs - per prescription or refill, subject to dispensing limits. Note: Retail Prescription Drugs will be considered an Essential Health Service unless prescribed drug is related to an Elective Treatment, subject to exclusions and other limitations of the Policy.		
4 Tier Plan	Participating Pharmacy Benefit	Non-Participating Pharmacy Benefit
1. Generic Drugs	100% of R&C after \$15 Copayment	60% of R&C
2. Preferred Brand Drugs	100% of R&C after \$35 Copayment	60% of R&C
3. Non-Preferred Brand Drugs	100% of R&C after \$60 Copayment	60% of R&C
4. Specialty Drugs	100% of R&C after \$60 Copayment	60% of R&C

- Only a thirty (30) day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy).
- One (1) Copayment per thirty (30) day supply. No cost sharing applies to Generic Contraceptives.
- Includes prescription contraceptives which have been approved by the FDA, prescribed pre-natal vitamins and smoking deterrent prescription medications.
- Includes medications, equipment and supplies for the management and treatment of diabetes.
- The Deductible does not apply at a Participating Pharmacy.
- The same cost sharing will apply to orally administered cancer drugs as that applied to intravenously or inject cancer drugs.
- Coverage will not be denied or limited for prescription inhalants to Covered Persons suffering from asthma or other life-threatening bronchial ailments based upon any restriction on the number of days before an inhaler refill may be obtained if, contrary to those restrictions, the inhalants have been ordered or prescribed by the treating physician and are Medically Necessary.
- 60 day written or electronic notice will be given to You prior to making any formulary change that alters the terms of coverage if You are receiving immunosuppressant drugs or discontinues coverage for a prescribed immunosuppressant drug that You are receiving. The notification will disclose the formulary change, indicate that the prescribing Physician may initiate an appeal, and include information regarding the procedure for the prescribing Physician to initiate the Plan's appeal process. This notice may be received at the time You request a refill along with a 60-day supply of the immunosuppressant drug.

Covered Charges –Elective Treatment

Note: All services are per Policy Year unless otherwise noted.

Elective Treatment

Non-emergency coverage outside of the United States, if not covered by any other coverage.

Maximum Benefit: \$20,000 at 60% of actual charges.

COORDINATION OF BENEFITS

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

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

SUBROGATION AND RECOVERY RIGHTS

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

EXCLUSIONS

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

1. Eyeglasses, contact lenses, routine eye refractions, eye examinations except as in the case of Injury, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.
2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids and the fitting or repairing or replacement of hearing aids, except 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 (except capsular or bone surgery, any type of massage procedure on or to the foot, corrective shoes and shoe inserts. This exclusion does not apply when related to diabetes, illness or disease, treatment of infections which result from an accidental Injury, or infections which result from an accidental, involuntary, or unintentional ingestion of a contaminated substance.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that are to be furnished primarily to improve appearance rather than a physical function or control of organic disease 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 application of breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections and reductive mammoplasty when Medically Necessary); rhinoplasty. This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part.

6. Sexual/gender reassignment surgery, except as provided when determined to be Medically Necessary or when treatment is otherwise covered under the Policy in the absence of a diagnosis of gender dysphoria. This exclusion does **not** include related mental health counseling or hormone therapy.
7. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved.
8. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications.
9. Custodial Care; long-term care.
10. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, (except as specified herein or when specifically and directly related to the treatment of a Medical Condition.)
11. 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.
12. Injury sustained by reason of a motor vehicle Accident to the extent that Benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such Benefits.
13. Injury resulting from participation in any hazardous activity, including: travel in or upon a snowmobile, ATV (all terrain or similar type two or three wheeled vehicle and/or off-road four wheeled motorized vehicles motor vehicles not primarily designed and licensed for use on public streets or highways, parachuting, hang gliding, skydiving, parasailing, scuba diving, skin diving, glider flying, sailplaning, racing or speed contests, mountaineering (where ropes or guides are customarily used), rock wall climbing, rodeo or bungee jumping; (except as specifically provided in this Policy).
14. Injury occurring in consequence of riding as a passenger or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.

15. Reproductive/services, unless caused by Injury or Sickness, including but not limited to: family planning, premarital examination; impotence, organic or otherwise; sterilization reversal; and vasectomy reversal.
16. Elective termination of pregnancy.
17. Hospital Confinement or any other services or treatment that are received without charge or legal obligation to pay.
18. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee.
19. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
20. Any services of a Physician or Nurse who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.
21. Services received before the Covered Person's Effective Date except as specifically provided under the Extension of Benefits provision.
22. 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;
 - sexual enhancement drugs;
 - cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in this Policy;
 - treatment of nail (toe or finger) fungus;
 - refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
 - for an amount that exceeds a thirty (30) day supply
 - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
 - purchased after Coverage under the Policy terminates;
 - consumed or administered at the place where it is dispensed;
 - if the FDA determines that the drug is:
 - i. contraindicated for the treatment of the Condition for which the drug was prescribed; or
 - ii. Experimental for any reason.
23. Services for the treatment of any Injury or Sickness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot.

24. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
25. War or any act of war, declared or undeclared; or while in the armed forces of any country.
26. 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.
27. Obesity treatment: Non-Medically Necessary Services and associated expenses for the treatment of obesity, except nutrition counseling specifically provided in the Policy, and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:
 - Wiring of the jaw;
 - Appetite suppressants;
 - Surgery for removal of excess skin or fat.
28. 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.
29. All services preformed to prepare the mouth for the application, fitting or use of dentures.
30. Elective Treatment, except as specified in the Schedule of Benefits.

CLAIM PROCEDURES

In the event of either an Injury or a Sickness:

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

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: S215016

CLAIM APPEAL PROCESS

You, an authorized person, or a Provider, with Your consent, may submit a written appeal to Us if Coverage is denied, reduced or terminated. Appeals must be received within one hundred eighty (180) days of the date the Covered Person receives written notification of the denial. Appeals should be sent to:

Nationwide Life Insurance Company
 Attention: Consolidated Health Plans
 2077 Roosevelt Ave.
 Springfield, MA 01104
 Toll Free Number: 1-800-633-7867
 Fax Number: 413-733-4612

The receipt of the grievance or appeal will be acknowledged in writing within seven (7) days. The appeals staff will review all of the information. A decision will be made within thirty (30) calendar days of receipt for a Pre-Service Claim Appeal and within sixty (60) calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to an additional sixty (60) calendar days if additional information is needed. You will be notified in writing of the Appeals Department's decision.

A Post-Service Claims Appeal is an appeal of a decision to deny or reduce Benefits for claim that has already been incurred.

This plan is underwritten by:
 Nationwide Life Insurance Company
 Columbus, OH
 Policy Number: 302-004-1214

For a copy of the Company's privacy notice you may go to:
www.consolidatedhealthplan.com/about/hipaa
 Or
 Request one from the Health Office at your School

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

Representations of this plan must be approved by the Company.

VALUE ADDED SERVICES

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

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. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 1.877.488.9833 or if you are in a foreign country, call +1.609.452.8570.** 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.

*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.