Student Health Insurance Plan
Designed for the Students of

Friends University

2016-2017

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH

Policy Number: 302-001-1514
Group Number: S216616
Effective: 8/1/2016 to 7/31/17

Administered by:

Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

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WHERE TO FIND HELP

For Questions About:  Please Contact:

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<th>Insurance Benefits</th>
<th>Consolidated Health Plans</th>
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<tr>
<td>Preferred Provider Listings</td>
<td>Springfield, Massachusetts 01104</td>
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<tr>
<td>Claims Processing</td>
<td>(800) 633-7867</td>
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<tr>
<td>Id Card Requests</td>
<td><a href="http://www.chpstudent.com">www.chpstudent.com</a></td>
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<tr>
<th>Preferred Provider Listings</th>
<th>Consolidated Health Plans or First Health PPO</th>
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<tbody>
<tr>
<td></td>
<td><a href="http://www.firsthealth.com">www.firsthealth.com</a> (800) 226-5116</td>
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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.

CREDIT HOUR REQUIREMENTS

All registered undergraduate students taking 6 or more credit hours, graduate students and international students are eligible to enroll in this plan.

International students are required to purchase this plan at registration. New international students are automatically enrolled.

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 registered undergraduate students taking 6 or more credit hours, graduate students and returning international students are eligible to enroll in this plan on a voluntary basis.

Domestic full time and graduate students can enroll by completing an online enrollment form, refer to the website link below.

International students are required to purchase this plan at registration. New international students are automatically enrolled and the premium is charged to the student’s account.

ENROLLMENT PERIOD DEADLINES:

ANNUAL WAIVER DEADLINE – September 23, 2016
SPRING/SUMMER DEADLINE – February 1, 2017
SUMMER DEADLINE – July 1, 2017

IN Krankenversicherung

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

<table>
<thead>
<tr>
<th></th>
<th>Annual*</th>
<th>Fall*</th>
<th>Spring*</th>
<th>Summer*</th>
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<tr>
<td></td>
<td>8/1/2016-7/31/2017</td>
<td>8/1/2016-12/31/2016</td>
<td>1/1/2017-7/31/2017</td>
<td>6/1/2017-7/31/2017</td>
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<tr>
<td>Student</td>
<td>$1,351</td>
<td>$566</td>
<td>$785</td>
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*The above rates include an administrative fee.

TERMINATION OF BENEFITS

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. 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 no other cause, results in an Injury.

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

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

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

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

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

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

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

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

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

Confinement/Confined: An uninterrupted stay following admission to a Health Care Facility. The re-admission to a Health Care Facility for the same or related Condition, within a seventy-two (72) hour period, will be considered a continuation of the Confinement. Confinement/Confined 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:** An Illness, Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid severe harm.

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.

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

**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 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;
  - Licensed vocational nurse
  - Medical social services;
  - Infusion services;
  - Home Care education associated with diabetes, colostomy care, wound care, IV therapy
  - Part-time or intermittent certified nurse assistant services or home health aide services, which provide support in the home under the supervision of an R.N. or a physical, speech or occupational therapist. A visit of four (4) hours or less by a certified nurse assistant or home health aide will count as one (1) Home Health Care visit. Each visit by any other home health agency representative will count as one (1) Home Health Care visit;
    - Physical Therapy;
    - Occupational therapy;
    - Speech Therapy.

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

**Hospital:** A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. Hospital also includes an Ambulatory Surgical Center or ambulatory medical center, and a birthing facility certified and licensed as such under the laws where located. It shall also include Rehabilitative facilities if such is specifically required for treatment of physical disability.

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

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

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

**Illness:** Sickness or disease.

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

**Injectable Drugs:** Means a 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, bodily infirmity or any other causes. All injuries sustained in any one (1) Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

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

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

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

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

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

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

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

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

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

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.

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 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.

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;

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

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

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

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

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

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

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

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

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 abuse or addiction; and
- Is operated pursuant to law.
Sound Natural Tooth: The major portion of the individual natural tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.
Specialty Drugs: Means a Prescription Drug including Injectable Drugs, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis, and which are listed in the specialty care drug list.
Standard Medical Reference Compendia: The following publications:
- The “AMA Drug Evaluations”, published by the American Medical Association;
- The “American Hospital Formulary Service (AHFS) Drug Information”, published by the American Society of Health System Pharmacists; or

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. www.firsthealth.com, or contact Consolidated Health Plans at (413) 733-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.

SCHEDULE OF BENEFITS

Actuarial Value: 78.61%
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.


<table>
<thead>
<tr>
<th>Policy Year Maximum Benefit</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insured</strong></td>
<td><strong>unlimited</strong></td>
<td></td>
</tr>
<tr>
<td>In-Network Benefit</td>
<td>Out-of-Network Benefit</td>
<td></td>
</tr>
<tr>
<td>Deductible (except as specified herein) per Condition per Covered Person.</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>*Deductible:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Benefits are subject to Deductible unless otherwise indicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The Deductible shall <strong>not</strong> apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o In-Network Preventive/wellness exams and immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Copayments do not apply to Deductibles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured Percent (except as specified herein)</td>
<td>80% of the Preferred Allowance (PA)</td>
<td>60% of the Reasonable and Customary Charges (R&amp;C)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Person</td>
<td>$3,750</td>
<td>$7,500</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Includes Coinsurance, Copayments and Deductibles;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Excludes non-covered medical expenses and Elective Treatment;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year;</td>
<td></td>
<td></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>
<td></td>
<td></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>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Charge</th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care (See Definition for additional information.)</td>
<td>100% of PA Deductible waived</td>
<td>70% of R&amp;C</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>80% of PA after a $40 per visit co-pay</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Outpatient Services - Other than Surgery or Maternity Services</td>
<td></td>
<td></td>
</tr>
<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. Limited to one (1) visit per day and does not apply when related to surgery.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Consulting Physician (other than Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician): Limited to one (1) visit per day and does not apply when related to surgery.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>PSA Testing and Digital Exams</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Bone Density Testing (Limited to one (1) test per Policy Year)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic Imaging - Includes x-ray services which are diagnostic or therapeutic.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>CT Scan, MRI, and /or PET Scans</td>
<td>80% of PA after $500 Copayment per Procedure</td>
<td>60% of R&amp;C after $500 Copayment per Procedure</td>
</tr>
<tr>
<td>Infusions (done in an Outpatient Health Care Facility or Physician’s office)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Injections (done in an Outpatient Health Care Facility or Physician’s office)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Procedure</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>Radiation</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - Includes administration and supplies.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

**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. **NOTE:** Only one (1) Copayment amount for Room and Board applies to each admission for the same Condition. | 80% of PA after $500 Copayment per Confinement | 60% of R&C after $500 Copayment per Confinement |
| Intensive Care Room  
**NOTE:** Only one (1) Copayment amount for Room and Board applies to each admission for the same Condition. | 80% of PA | 60% of R&C |

**Physician visit, during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility.**
- Limited to one (1) visit per day
- Does not apply when related to surgery

| Consulting Physician, when requested and approved by the Attending Physician Limited to one (1) visit per Consulting Physician per day | 80% of PA | 60% of R&C |

**Skilled Nursing Facility and Sub-Acute Care Facility.**
- Includes semi-private room and board, general nursing services, meals and prescribed diets, supplies, Diagnostic Imaging, Laboratory, Rehabilitation.

| 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 | 80% of PA | 60% of R&C |
| Assistant Surgeon | 25% Surgeon’s Payments | 25% Surgeon’s Payments |
| Anesthetist Services | 25% Surgeon’s Payments | 25% Surgeon’s Payments |
### Inpatient Surgical
**Miscellaneous** - Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.

<table>
<thead>
<tr>
<th>Service</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
</table>

### Outpatient Surgical Services

<table>
<thead>
<tr>
<th>Role</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>25% Surgeon’s Payments</td>
<td>25% Surgeon’s Payments</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>25% Surgeon’s Payments</td>
<td>25% Surgeon’s Payments</td>
</tr>
</tbody>
</table>

### Outpatient Surgical Day Surgical Miscellaneous
Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.

<table>
<thead>
<tr>
<th>Service</th>
<th>80% of PA after a $500 Copayment</th>
<th>60% of R&amp;C after a $500 Copayment</th>
</tr>
</thead>
</table>

### Other Surgical Services (Inpatient/Outpatient)

<table>
<thead>
<tr>
<th>Service</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>
<tr>
<td>Reconstructive Surgery - Coverage is provided to restore normal form or function after injury, surgery or congenital defect. Includes reconstruction of the breast post-mastectomy.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Organ Transplant Surgery - Coverage is provided for bone marrow, cornea, heart, heart-lung, kidney, pancreas, liver, lung (whole, lobar, single or double), small intestine, peripheral stem cell and multivisceral transplants. Includes coverage for the removal of an organ from a live donor</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

### Donor Search Services
Coverage is provided for donor search and acquisition of bone marrow and peripheral stem cells when no related donor is available.

<table>
<thead>
<tr>
<th>Service</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
</table>

### Reproductive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Diagnostic Services - Includes counseling, planning services and treatment for injury, disease or condition that is the underlying cause of infertility, including treatment of sexual dysfunction. Excludes assisted reproduction procedures, including but not limited to, in-vitro fertilization, embryo or ovum transfers, fees to surrogate parent and harvest or storage of eggs or sperm. Coverage is not provided for Dependent Children.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Voluntary Sterilization Surgery - Note: Sterilization procedures for women are covered under Preventive Care.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Paid as any other Sickness</th>
<th>Paid as any other Sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Diagnostic services performed and billed by a Physician’s office, including ultrasounds and amniocentesis.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Mental Conditions and Alcoholism/Drug Abuse</td>
<td></td>
<td></td>
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<tr>
<td>--------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Inpatient services (including Alcoholism and Drug detoxification).</td>
<td>Paid as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>Paid as any other Sickness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Office Visits</td>
<td>Paid as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>Paid as any other Sickness</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Care and Emergency Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Facility (non-Emergency) services</td>
<td></td>
</tr>
<tr>
<td>Note: The Copayment amount for this visit is waived if You are referred to an Emergency room or admitted to a Hospital</td>
<td></td>
</tr>
<tr>
<td>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. Note: The Copayment amount for this visit is waived if You are referred to an Emergency room or admitted to a Hospital for the same Condition within forty-eight (48) hours of the visit. Follow-up care at the Emergency room is not covered.</td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Transportation services</td>
<td>80% of PA</td>
</tr>
<tr>
<td>60% of R&amp;C</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing</td>
<td>80% of PA</td>
</tr>
<tr>
<td>60% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>80% of PA</td>
</tr>
<tr>
<td>60% of R&amp;C</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |
| |  |
| serum, and supplies used for allergy therapy. |  |
| 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. |  |
| 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. Excludes vocational and cognitive therapies. |  |
| Physical Therapy - limited to one (1) visit per day. | 80% of PA  |
| 60% of R&amp;C  |  |
| Occupational Therapy | 80% of PA  |
| 60% of R&amp;C  |  |
| Speech Therapy | 80% of PA  |
| 60% of R&amp;C  |  |
| Pulmonary Therapy | 80% of PA  |
| 60% of R&amp;C  |  |
| Cardiac Therapy | 80% of PA  |
| 60% of R&amp;C  |  |
| Respiratory Therapy | 80% of PA  |
| 60% of R&amp;C  |  |
| Spinal Manipulation Therapy - Includes x-rays, office visits, laboratory services, manipulations and modalities (i.e., hot packs, cold packs and ultrasounds, etc.), regardless of Provider type. | 80% of PA  |
| 60% of R&amp;C  |  |
| Dermatology | 80% of PA  |
| 60% of R&amp;C  |  |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>PA Coverage</th>
<th>R&amp;C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatry <strong>Note:</strong> Routine foot care is Covered when systemic Conditions, such as metabolic, neurologic, or peripheral vascular disease, exist and result in medically significant circulatory deficits or decreased sensation to the foot.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Home Health Care services. Educational visits are limited to three (3) per Policy Year.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Private Duty Nursing Care</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospice - Limited to Covered Persons with a life expectancy of six (6) months or less.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Bereavement Services for Family Members - Limited to ninety (90) days following the Covered Person’s date of death.</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>Osteoporosis Treatment and Management</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) Includes:</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>- Coverage for foot orthotics for Covered Persons with Diabetes.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>- Coverage for two (2) post mastectomy bras per Covered Person per Policy Year.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>- Coverage for prosthetic and orthotic devices.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Dental treatment due to Injury to a Sound Natural Tooth not including broken fillings or damage caused by biting or chewing.</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 surgery of the jaw to correct or treat TMJ.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Treatment for an impacted tooth.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Intercollegiate, Intramural and Club Sports</td>
<td>Paid as any other Injury</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>100% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Pediatric Dental – preventive &amp; diagnostic services, for Covered Persons under the age of nineteen (19). Limited to 1 exam / prophylaxis every 6 month. Includes:</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- Topical fluoride treatment – 3 per 12 months</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- x-rays – bitewing – limited to $60 per visit</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- x-rays - full-mouth and panoramic – 1 per 36 months</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth per 12 months)</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- space maintainers – 1 per 12 months per arch/quadrant; includes re-cementation 6 months after initial installation</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Pediatric Dental – basic restorative services, for Covered Persons under the age of nineteen (19). Includes:</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- fillings (amalgam, resin-based composite)</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- prefabricated stainless steel crown – 1 per tooth per 24 months</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- endodontics - therapeutic pulpotomy – one per tooth per lifetime</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>- simple extractions</td>
<td>70% of R&amp;C</td>
<td></td>
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<tr>
<td>- prosthodontics – denture repair, 6 months after initial installation, denture reline (1 per 24 months; 24 months after initial installation)</td>
<td>70% of R&amp;C</td>
<td></td>
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</tbody>
</table>
Pediatric Dental – major services, for Covered Persons under the age of nineteen (19).

Includes:
- prosthodontics - metal, metal/porcelain, and porcelain crowns – 1 per tooth per 60 months
- prosthodontics – complete or partial dentures - 1 time every 60 months; for partial dentures, must include replacement of 1 or more anterior teeth, 2 or more posterior teeth unilaterally, or 3 or more posterior teeth bilaterally, excluding 3rd molars
- endodontics – root canals on permanent teeth - limited to one per tooth per lifetime
- periodontics – including gingivectomy, gingivoplasty, scaling and root planing - limited to 4 quadrants per 12 months (minimum of 4 affected teeth) or 4 per 12 months (1 to 3 affected teeth in quadrant)
- full mouth debridement – 1 per 12 months
- oral surgery
- general anesthesia and IV sedation – in conjunction with complex oral surgery
- analgesia (nitrous oxide) – not covered when billed with only preventive/diagnostic services

Pediatric Dental – Medically Necessary orthodontia services *, for Covered Persons under the age of nineteen (19) with severe and handicapping malocclusion (including genetic deformity or traumatic facial injury resulting in serious health impairment). Includes:
- pre-orthodontic treatment
- orthodontic treatment
- appliance therapy
- orthodontic retention
*Requires pre-authorization

Pediatric Vision for Covered Persons under the age of nineteen (19).

Includes:
- 1 exam/fitting per Policy Year, including dilation if professionally indicated
- prescription eyeglasses (lenses and frames) – limited to three (3) pair per year, including repairs and adjustments as needed
- Medically Necessary contact lens in lieu of eyeglasses.

<table>
<thead>
<tr>
<th>Outpatient Prescription Drugs</th>
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</thead>
<tbody>
<tr>
<td>Retail Prescription Drugs - per prescription or refill, subject to dispensing limits.</td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>4 Tier Plan</th>
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</thead>
<tbody>
<tr>
<td>1. Generic Drugs</td>
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<tr>
<td>2. Preferred Brand Drugs</td>
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<tr>
<td>3. Non-Preferred Brand Drugs</td>
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<tr>
<td>4. Specialty Drugs</td>
</tr>
</tbody>
</table>

You will need to file a claim form for reimbursement. Save Your receipt and call Our customer service department to request a form.
- Only a 30 day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy).
- One (1) Copayment per thirty (30) day supply. No cost sharing applies to Generic Contraceptives or other Preventive Services drugs.
- 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 apply.

<table>
<thead>
<tr>
<th>Covered Charges – Elective Treatment (non-essential health benefits)</th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Treatment</td>
<td></td>
<td></td>
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<tr>
<td>Non-emergency out-of-country coverage</td>
<td></td>
<td>60% of actual charges</td>
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<tr>
<td><strong>Maximum Benefit:</strong></td>
<td></td>
<td></td>
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<tr>
<td>$20,000 per Policy Year</td>
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</table>

**MANDATED BENEFITS**

Benefits subject to applicable Deductible, Coinsurance, and Copayments as outlined in the Schedule of Benefits.  **Note:** Wellness/Preventive Benefits under the Affordable Care Act (ACA) are required to meet federal regulations; no cost sharing will apply to these benefits for In-Network services. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate.
Anesthesia for Dental Services
Coverage is provided for the administration of general anesthesia and medical care facility charges for dental care provided to the following covered persons:
1. A child five years of age and under; or
2. A person who is severely disabled; or
3. A person has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Breast Reconstruction
Coverage is provided for:
1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Diabetes
Coverage is provided for equipment, and supplies, limited to hypodermic needles and supplies used exclusively with diabetes management and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a Provider. Such coverage shall include coverage for insulin only if such coverage also includes coverage of prescription drugs.

Direct Access to Obstetricians and Gynecologists
Access to an in-network obstetrician or gynecologist for routine gynecological care from an in-network obstetrician or gynecologist is allowed without a referral from a primary care Provider.

Mammogram and Pap Smear
Coverage is provided for mammograms or pap smears when performed at the direction of a person licensed to practice medicine and surgery by the board of healing arts within the lawful scope of such person's license, including services performed at a mobile facility certified by the federal health care financing administration and performing mammography testing by American Cancer Society guidelines or when a Physician deems a mammography examination to be Medically Necessary.

Oral Anticancer Medication
Coverage is provided for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits. Deductibles, coinsurance and other limitations as apply to other covered services.

Off Label Drugs for Cancer
Coverage is provided for a Prescription Drug for cancer treatment if the Prescription Drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. The prescribing Physician shall submit documentation to Us supporting the proposed off-label use or uses if requested.

Osteoporosis
Coverage is provided for the diagnosis, treatment and management of osteoporosis when such services are provided by a Provider, for Covered Persons with a condition or medical history for which bone mass measurement is medically necessary for such individual.

Prostate Cancer Screening
Coverage is provided for prostate cancer screening for men forty (40) years of age or over who are symptomatic or in a high-risk category and for all men fifty (50) years of age or older. The screening shall consist, at a minimum, of a prostate-specific antigen blood test and a digital rectal examination.

Routine Costs: Cancer Clinical Trials
Coverage is provided for routine costs for patients undergoing cancer clinical trials if the following conditions are met:
1. The Covered Person has been diagnosed with cancer and accepted into a phase I, II, III, or phase IV clinical trial for cancer.
2. The treating Physician who is providing covered health care services recommends participating in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Insured.

Routine costs include: drugs, items, devices, treatments, diagnostics, and services that would otherwise be covered under the Policy if those services were not provided in connection with an approved clinical trial program, including health care services typically provided to patients not participating in a clinical trial.
PEDICATRIC DENTAL AND VISION

PEDICATRIC VISION SERVICES

Please refer to the Schedule of Benefits section of this Policy for cost-sharing requirements, day or visit limits. We cover emergency, preventive and routine vision care for Covered Persons up to age nineteen (19). This Benefit terminates on the first of the month following the Covered Person’s 19th birthday.

Exclusions for this Pediatric Vision Services Benefit

No Benefit will be paid for:

1. Any charges for failure to keep a scheduled appointment;
2. Any service charges for personalization or characterization of prosthetic appliances;
3. Office infection control charges;
4. Medical treatment of eye disease or injury;
5. Visual therapy;
6. Special lens designs or coatings;
7. Non-prescription (Plano) lenses;
8. Two pairs of eyeglasses in lieu of bifocals;
9. Optometric prosthetic devices and services;
10. Insurance of contact lenses.

All other terms, provisions, limitations and general exclusions listed within this Policy still apply.

PEDICATRIC DENTAL SERVICES

Please refer to the Schedule of Benefits section of this Policy for cost-sharing requirements, day or visit limits, and any applicable pre-authorization or waiting period requirements. We cover preventive and diagnostic, basic restorative, major and Medically Necessary orthodontia services for Covered Persons up to age nineteen (19). Medically Necessary orthodontia services are limited to Covered Persons with severe and handicapping malocclusion. This Benefit terminates on the first of the month following the Covered Person’s 19th birthday.

Alternative Benefits

There is often more than one Service that can be used to treat a dental problem or disease. In determining the Benefits payable on a claim, different materials and methods of treatment will be considered. The amount payable will be limited to the Covered Expense for the least costly service, which meets broadly accepted standards of dental care. The Covered Person and his or her Provider may decide on a more costly procedure or material for the treatment of the condition. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits payable for Covered Expenses for the least costly Service. We will not pay the excess amount.

Exclusions for this Pediatric Dental Services Benefit

No Benefit will be paid for:

1. Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In those states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
2. Services and treatment resulting from your failure to comply with professionally prescribed treatment;
3. Any charges for failure to keep a scheduled appointment;
4. Any service charges for personalization or characterization of prosthetic dental appliances;
5. Services related to the diagnosis and treatment of Temporomandibular Joint Disorder (TMJ), except as otherwise covered under this Policy;
6. Office infection control charges;
7. Duplicate, provisional and temporary devices, appliances, and services;
8. Plaque control programs, oral hygiene instruction, and dietary instructions;
9. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
10. Gold foil restorations;
11. Charges by the provider for completing dental forms;
12. Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
13. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
14. Sealants for teeth other than permanent molars;
15. Precision attachments, personalization, precious metal bases and other specialized techniques;
16. Replacement of dentures that have been lost, stolen or misplaced;
17. Medically Necessary orthodontic services provided to a Covered Person who has not met any applicable waiting period requirement.
18. Repair of damaged orthodontic appliances;
19. Replacement of lost or missing appliances;
20. Fabrication of athletic mouth guard;
21. Internal bleaching;
22. Non-intravenous conscious sedation;
23. Topical medicament center;
24. Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.

All other terms, provisions, limitations and general exclusions listed within this Policy still apply.
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.

RECOVERY RIGHTS
Right of Recovery: If the amount of the payment made by Us is more than We should have paid under this Policy, We have the right to correct benefit payments that are made in error. Providers and/or You have the responsibility to return any overpayments to Us. We have the responsibility to make additional payments if any underpayments have been made.

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. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker’s compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker’s compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement. In addition, if You are covered by a worker’s compensation program which limits benefits when other than specified providers are used and You receive services from a non-specified provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.

2. Services in which duplicate benefits are available under federal, state or local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran’s facility when the services are eligible for coverage by the government. This contract will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D. Waiving Your rights to these services shall include failure to purchase coverage under any such government programs, including Medicare Parts A and B, when You are eligible to purchase such coverage.

3. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.

4. Services that are not Medically Necessary, as defined in the Policy.

5. Services provided by Institutional and Professional Providers for unnecessary Inpatient admissions when services and evaluations that could satisfactorily be provided on an Outpatient basis.

6. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.

7. Procedures and diagnostic tests that are considered to be obsolete by a professional medical-advisory committee.

8. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion or aggression.

9. Any service or supply associated with the treatment of obesity. This includes but is not limited to, surgery, office visits, hospitalizations, laboratory or radiology services, Prescription Drugs, medical weight reduction programs, nutrients and diet counseling, except for those services covered as Preventive Care.

10. Inpatient skilled care, intermediate care, convalescent care, custodial/maintenance care or rest cures.

11. Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older.

12. Services or supplies associated with sex changes/gender reassignment, services related to sexual function and any related complications.

13. Reversal of sterilization procedures.


15. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.

16. Cosmetic or reconstructive surgery except when the surgical procedure in one of the following:
   a. Cosmetic or reconstructive repair of an Accidental Injury.
   b. Reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from Illness or Injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance.
c. Repair of congenital abnormalities and hereditary complications or conditions, limited to:
   (1) Cleft lip or palate.
   (2) Birthmarks on head or neck.
   (3) Webbed fingers or toes.
   (4) Supernumerary fingers or toes.

d. Reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic processes.

17. Refractive procedures including radial keratotomies, corneal relaxation, keratophakia, keratomileusis or any other procedure used to reshape the corneal curvature except for Medically Necessary procedures associated with severe anisometropia.

18. Health services associated with Accidental Injury arising from a motor vehicle Accident to the extent such services are payable under a medical expense payment provision of any automobile insurance policy.

19. Services for personal items such as television, radio, telephone, comfort kits, materials used in occupational therapy, air conditioning provided on an optional basis or internet access.

20. Services where the Provider would normally make no charge or Provider charges for travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone, services provided through e-mail or electronic communications. For the purpose of this provision, electronic communications means communication other than telemedicine. Telemedicine means the use of telecommunications technology to provide, enhance or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals or transmitting x-rays or other diagnostic images for examination at another site.

21. Services by an immediate relative or member of Your household. "Immediate relative" means the husband or wife, children, parents, brother, sister or legal guardian of the person who received the service. "Member of Your household" means anyone who lives in the same household and who was claimed by You as a tax deduction for the year during which the service was provided.

22. Repair or replacement of dental plates and all dental care other than that listed as a Covered Service. This includes any service associated with dental implants, including surgical treatment or diagnostic services except as otherwise stated in the Policy. This also includes dental appliances or restorations necessary to increase vertical dimensions or restore the occlusion.

23. The fitting of hearing aids, servicing of visual corrective devices or consultations related to such services; orthoptic and visual training, except as provided in the Policy.


25. Drugs which are available in an equivalent dose over-the-counter and which do not require a prescription by federal or state law, except as specifically provider under Preventive Care.

26. Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders IV (1994) which are not attributable to a Mental Condition and are a focus of clinical attention, e.g., marriage counseling. This exclusion applies to all benefits provided by this contract; it is not limited to those benefits listed for Mental Conditions or Alcoholism/Drug Abuse.

27. Non-medical services (including but not limited to, legal services, social rehabilitation, educational services, vocational rehabilitation, job placement services).

28. Services for or related to elective termination of pregnancy, except to preserve the life of the female upon whom the abortion is performed.

29. Adult eye examinations to determine the need for vision correction, unless specifically provided in the Policy.

CLAIM PROCEDURES

In the event of either an Injury or a Sickness:

1. Report to their Physician, Hospital or the Friends University 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: S216616
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.

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

**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.