Student Health Insurance Plan
Designed for the Students of

Stephen F. Austin State University (International)

2016-2017
Underwritten by:
Nationwide Life Insurance Company
Columbus, Ohio

Policy Number: 302-010-4214

Group Number: S214916

Effective: 8/15/2016-8/14/2017

Administered by:

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WHERE TO FIND HELP

<table>
<thead>
<tr>
<th>Enrollment Services</th>
<th><a href="http://www.chpstudent.com">www.chpstudent.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please select <a href="http://www.chpstudent.com">Stephen F Austin State University Domestic</a> from the drop down box and proceed as directed to enroll in the student health insurance plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance Benefits</th>
<th>Consolidated Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider Listings</td>
<td>2077 Roosevelt Avenue</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>Springfield, Massachusetts 01104</td>
</tr>
<tr>
<td>Id Card Requests</td>
<td>(800) 633-7867</td>
</tr>
<tr>
<td><a href="http://www.chpstudent.com">www.chpstudent.com</a></td>
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</tbody>
</table>

| Preferred Provider Listings | PHCS by MultiPlan go to [www.multiplan.com](http://www.multiplan.com) |

AM I ELIGIBLE?

You are eligible for Coverage if You meet the definition of Eligible Person as determined by the Policyholder and Us. Persons who meet the definition of a Dependent are also eligible for Coverage provided You are an Insured.

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 international students are automatically enrolled in the insurance plan. The following courses are excluded from being applied towards the required minimum credit hours: Distance learning or internet courses; Courses taken as audit; Home Study; Correspondence; and TV courses.

COVERAGE FOR DEPENDENTS

Insured students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents.

Individuals who enroll their Dependents must do so within thirty-one (31) days of the Insured Student’s enrollment in the plan except as provided in the policy or due to an involuntary loss of other coverage.

HOW DO I ENROLL?

Enrollment in this plan is voluntary. Students can enroll in the plan any time prior to the coverage period effective date though the end of the enrollment period deadline date (see below).

- **ANNUAL ENROLLMENT DEADLINE** – September 15, 2016
- **SPRING ENROLLMENT DEADLINE** – February 20, 2017

To enroll your eligible dependents please go to [www.chpstudent.com](http://www.chpstudent.com) and complete the enrollment process by the enrollment deadlines.

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

<table>
<thead>
<tr>
<th></th>
<th>Annual*</th>
<th>Fall</th>
<th>Spring</th>
<th>Summer</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>8/15/2016-8/14/2017</td>
<td>8/15/2016-1/19/2017</td>
<td>1/20/2017-8/14/2017</td>
<td>5/30/2017-8/14/2017</td>
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<tr>
<td>Student</td>
<td>$967</td>
<td>$419</td>
<td>$548</td>
<td>$204</td>
</tr>
<tr>
<td>Dependent rates are in addition to the student rate.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>$967</td>
<td>$419</td>
<td>$548</td>
<td>$204</td>
</tr>
<tr>
<td>Each Child</td>
<td>$967</td>
<td>$419</td>
<td>$548</td>
<td>$204</td>
</tr>
<tr>
<td>3 or more Children</td>
<td>$2,901</td>
<td>$1,257</td>
<td>$1,644</td>
<td>$612</td>
</tr>
</tbody>
</table>

*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.
- The last day of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined.

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 ninety (90) days 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.

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.

Anesthesiologist: 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.

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. 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 or as a Dependent;
• 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.
Dependent: A person who is the Insured’s:
• Lawful spouse.
• Domestic Partner.
• Child who is under the age of twenty-six (26).
• Child age twenty-six (26) or older who is incapable of self-sustaining
employment because of mental retardation or physical disability and
chiefly dependent on the Insured for support and maintenance. Please see
the Termination provision of this Policy for eligibility requirements.
The term child refers to the Insured’s:
• Natural child;
• Stepchild or foster child;
• Adopted child, including a child placed with the Insured for the purpose of
adoption, from the moment of placement as certified by the agency
making the placement. A child is considered to be the child of an Insured if
the Insured is a party to a suit in which the Insured seeks to adopt the
child.
• Foster child is a Dependent from the moment of placement with the
Insured as certified by the agency making the placement.
• A grandchild who is a Dependent of the Insured for federal tax purposes at
the time the application for Coverage of the grandchild is made.
• A child for whom the Insured or group member must provide medical
support under an order issued under Chapter 154, Family Code, or
enforceable by a court in this state.
Dermatology: The diagnosis and treatment of skin disorders. Covered
expenses do not include cosmetic treatment and procedures.
Domestic Partner: Two (2) individuals who, together, each meet all of the
following criteria set forth below:
1. Are eighteen (18) years of age or older.
2. Are competent to enter into a contract.
3. Are not the legal spouse of, nor the Domestic Partner of, any other person.
4. Are not related by lawful union;
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the Domestic Partner relationship voluntarily, willingly, and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, which includes joint responsibility for each other’s basic living expenses
8. Have maintained their relationship as a couple prior to obtaining the Coverage provided under this Policy and the Certificate.
9. Intend to continue the Domestic Partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner.

A copy of the signed affidavit may be required upon enrollment.

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. Coverage for Dependents will never be effective prior to the Insured’s Coverage.

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

**Habilitation 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. The post delivery care may be provided at the women’s home, a healthcare Provider’s office, a Health Care Facility, or another location determined to be appropriate.

- 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

  The care must be established, approved in writing and reviewed at least every two (2) months by the Attending Physician.

**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 prescription drugs 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 do 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 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 Partnership, age, birth, death, adoption, change in Spouse’s or Domestic 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 lawful union.

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. The Covered Person may be responsible for costs in excess of the Reasonable and Customary charge, up to the amount billed by the Out-of-Network Provider, except as indicated in the Preferred Provider Benefit provision.

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 except as specified in the Preferred Provider Benefit provision.

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.

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, 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 drugs 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.

Surrogate Parenting Agreement: One in which a woman agrees to become pregnant with the intent of surrendering custody of the child.

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.

PPO PLAN - PREFERRED PROVIDER INFORMATION

By enrolling in this Insurance Program, you have the PHCS by MultiPlan PPO Network of Participating Providers, providing access to quality health care at discounted fees. To find a complete listing of PHCS by MultiPlan PPO Network of Participating Providers, go to www.multiplan.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: 78.96%

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: PHCS by MultiPlan (www.multiplan.com).

EFFECTIVE DATE: 08/15/2016  POLICY ANNIVERSARY DATE: 08/14/2017

<table>
<thead>
<tr>
<th>Policy Year Maximum Benefit - Essential Health Benefits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Dependent</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>
In-Network Benefit | Out-of-Network Benefit
--- | ---
**Deductible** (except as specified herein) per Policy Year per Covered Person. | $200 | $400

**Deductible:**
- Benefits are subject to Deductible unless otherwise indicated.
- The Deductible shall not apply:
  - Preventive/wellness exams and immunizations
  - To Hearing Tests
- Copayments do not apply to Deductibles;
- In-Network Deductible applies to Out-of-Network Emergency Services

**Insured Percent** (except as specified herein)

<table>
<thead>
<tr>
<th></th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Person</td>
<td>80% of the Preferred Allowance (PA)</td>
<td>60% of the Reasonable and Customary Charges (R&amp;C)</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000 per Covered Person</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>$12,700 per family</td>
<td>None</td>
</tr>
</tbody>
</table>

**Out-of-Pocket Maximum**

<table>
<thead>
<tr>
<th></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</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100% of PA</td>
<td>60% of R&amp;C waivered</td>
</tr>
<tr>
<td>Outpatient Services - Other than Surgery or Maternity Services</td>
<td>80% of PA after $25 Copayment per visit</td>
<td>60% of R&amp;C after $25 Copayment per visit</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.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>- Limited to one (1) visit per day</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>- Does not apply when related to surgery or Physical Therapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>- Includes Consulting Physician / Specialists</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>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>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**Inpatient Services – Other than Surgery or Maternity Services**

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

<table>
<thead>
<tr>
<th>Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital.</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
</table>

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

| 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  
- Includes Consulting Physician / Specialists | 80% of PA | 60% of R&C |
|---|---|---|

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

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

**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 and 50% of the Benefit otherwise payable for the secondary procedures.

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

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

<table>
<thead>
<tr>
<th>Anesthetist Services</th>
<th>25% Surgeon’s Payments</th>
<th>25% Surgeon’s Payments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Inpatient Surgical Miscellaneous Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
</table>
### Outpatient Surgical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Outpatient Surgeon/Day Surgery</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Surgery Miscellaneous - Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.</td>
<td>80% after $500 Copayment per surgical event</td>
<td>60% after $500 Copayment per surgical event</td>
</tr>
</tbody>
</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%</td>
<td>60%</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Organ Transplant Surgery (including expenses for a live donor). <strong>NOTE:</strong> Transportation and lodging are not a Covered Expense under this Policy.</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</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 Services - We cover services for the diagnosis of infertility and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. This Policy does not cover comprehensive infertility services.</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Maternity Care– Includes forty-eight (48) hours of Inpatient care following an uncomplicated vaginal delivery and ninety-six (96) hours of Inpatient care following an uncomplicated 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>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Surgeries</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Diagnostic services performed and billed by a Physician’s office, delivery and Inpatient Physician visits for mother and baby.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Diagnostic services performed and billed by a Physician’s office, including ultrasounds and amniocentesis.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Maternal Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Inpatient services - Includes alcohol/drug detoxification.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient Office Visits - Includes partial, residential or day treatment.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Urgent Care and Emergency Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Urgent Care Facility (non Emergency) services</td>
<td>80% after $100 Copayment per visit</td>
<td>60% after $100 Copayment per visit</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 and supplies, and facility charges. <strong>• Copayment waived if admitted to Hospital</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Emergency Medical Transportation services</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Mental Illness and Chemical Dependency

<table>
<thead>
<tr>
<th>Service</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services - Includes alcohol/drug detoxification.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient Office Visits - Includes partial, residential or day treatment.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Urgent Care and Emergency Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Urgent Care Facility (non Emergency) services</td>
<td>80% after $100 Copayment per visit</td>
<td>60% after $100 Copayment per visit</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 and supplies, and facility charges. <strong>• Copayment waived if admitted to Hospital</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Emergency Medical Transportation services</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>
### Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Outpatient Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Allergy Injections/treatment</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habilitative Care - only when prescribed by the Attending Physician. Includes Outpatient Physical Therapy, occupational therapy, speech therapy, and chiropractic care for a function that did not previously exist, but would normally be expected to exist. Limited to thirty-five (35) visits each therapy per Policy Year.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Rehabilitative Care - only when prescribed by the Attending Physician. Includes Outpatient Physical Therapy, occupational therapy, Restorative Speech Therapy, and chiropractic care which is expected to result in significant return of function. Limited to one (1) visit per day; Physical Therapy (and chiropractic care) limited to thirty-five (35) visits per Policy Year.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Cardiac Therapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Pulmonary Therapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Dermatology</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Podiatry</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Home Health Care services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Note: Any Home Health Care visit limits do not apply to Maternity Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diabetic treatment and education</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>- Includes replacement, repair, fitting and adjustment for up to two (2) pairs of therapeutic footwear per Policy Year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hearing Aids - limited to one (1) hearing aid per thirty-six (36) month period.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>TMJ - diagnosis and 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>Outpatient Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- per prescription or refill, subject to dispensing limits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Tier Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Generic Drugs</td>
<td>80% of R&amp;C after $25 Copayment</td>
<td></td>
</tr>
<tr>
<td>2. Brand Drugs</td>
<td>80% of R&amp;C after $50 Copayment</td>
<td></td>
</tr>
<tr>
<td>You will need to file a claim form for reimbursement. Save Your receipt and call Our customer service department to request a form.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Only a thirty (30) day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One (1) Copayment per thirty (30) day supply. No cost sharing applies to Generic Contraceptives.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Includes prescription contraceptives and devices 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.

**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.**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Percentage Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Dental – preventive &amp; diagnostic services, for Covered Persons under the age of nineteen (19). Limited to 1 exam / prophylaxis every 6 month.</strong></td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
</tr>
<tr>
<td>- Topical fluoride treatment – 2 per 12 months</td>
<td></td>
</tr>
<tr>
<td>- x-rays – bitewing – 1 set per 6 months</td>
<td></td>
</tr>
<tr>
<td>- x-rays - full-mouth and panoramic – 1 per 60 months</td>
<td></td>
</tr>
<tr>
<td>- sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months)</td>
<td></td>
</tr>
<tr>
<td>- space maintainers</td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric Dental – basic restorative services for Covered Persons under the age of nineteen (19).</strong></td>
<td>70% of R&amp;C</td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
</tr>
<tr>
<td>- emergency palliative treatment of pain</td>
<td></td>
</tr>
<tr>
<td>- fillings (amalgam, resin-based composite)</td>
<td></td>
</tr>
<tr>
<td>- prefabricated stainless steel crown – 1 per tooth per 60 months</td>
<td></td>
</tr>
<tr>
<td>- endodontics - therapeutic pulpotomy</td>
<td></td>
</tr>
<tr>
<td>- periodontics - scaling and root planning, limited to 1 every 24 months</td>
<td></td>
</tr>
<tr>
<td>- prosthodontics – denture repair, denture rebase/reline (1 per 36 months; 6 months after initial installation)</td>
<td></td>
</tr>
<tr>
<td>- oral surgery</td>
<td></td>
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<tr>
<td><strong>Pediatric Dental – major services for Covered Persons under the age of nineteen (19).</strong></td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
</tr>
<tr>
<td>- prosthodontics - crowns, bridges, and dentures - 1 per tooth/arc every 60 months</td>
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<tr>
<td>- endodontics (root canals on permanent teeth limited to one per tooth per lifetime)</td>
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<tr>
<td>- periodontics – gingivectomy or gingivoplasty,</td>
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<tr>
<td>limited to 1 every 36 months for four or more teeth</td>
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<tr>
<td>- general anesthesia and IV sedation – in conjunction with complex oral surgery</td>
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</tbody>
</table>

Pediatric Dental – Medically Necessary orthodontia services*, for Covered Persons under nineteen (19) with severe and handicapping malocclusion

Includes:
- pre-orthodontic treatment
- orthodontic treatment
- appliance therapy
- orthodontic retention
*Requires pre-authorization

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Percentage Coverage</th>
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<tbody>
<tr>
<td><strong>Routine Vision Exam for Covered Persons under nineteen (19).</strong></td>
<td>100 % up to $150, then 50%</td>
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<tr>
<td>Includes:</td>
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<tr>
<td>- 1 exam/fitting per Policy Year, including dilation if professionally indicated</td>
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<tr>
<td>- prescription eyeglasses (lenses and frames), or one (1) year supply of contact lens in lieu of eyeglasses, limited to once per Policy Year;</td>
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<tr>
<td>- glasses include glass or plastic lenses with frames including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses; polycarbonate prescription lenses with scratch resistance coating</td>
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<tr>
<td>- contact lenses include medically necessary contact lenses for the conditions of Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism</td>
<td></td>
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<tr>
<td>- 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.</td>
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</tbody>
</table>

*Requires pre-authorization
Acquired Brain Injury Services
Coverage is provided for Medically Necessary cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury. Coverage is provided for Medically Necessary post-acute transition services, community reintegration services, including outpatient day treatment services, or other post-acute care treatment as a result of and related to an acquired brain injury.

Coverage provided for reasonable expenses related to periodic reevaluation of the care of a Covered Person who has incurred an acquired brain injury, been unresponsive to treatment, and becomes responsive to treatment at a later date.

Coverage detailed by this provision for Covered Persons who have incurred an acquired brain injury is not impacted by related visit limits detailed in the Schedule of Benefits.

Definitions:
Acquired brain injury — A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Cognitive communication therapy — Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
Cognitive rehabilitation therapy — Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
Community reintegration services — Services that facilitate the continuum of care as an affected individual transitions into the community.
Neurobehavioral testing — An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
Neurobehavioral treatment — Interventions that focus on behavior and the variables that control behavior.
Neurocognitive rehabilitation — Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
Neurocognitive therapy — Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
Neurofeedback therapy — Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters and which are designed to result in improved mental performance and behavior, and stabilized mood.
Neurophysiological testing — An evaluation of the functions of the nervous system.
Neurophysiological treatment — Interventions that focus on the functions of the nervous system.
Neuropsychological testing — The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
Neuropsychological treatment — Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
Outpatient day treatment services — Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.
Post-acute care treatment services — Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a

<table>
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<tr>
<th>Covered Charge</th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
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<tbody>
<tr>
<td>Elective Treatment</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
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Maximum Benefit: $20,000 per Policy Year; 60% of Actual Charge.
treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute transition services — Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing — An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment — Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation — The process(es) of restoring or improving a specific function.

Services — The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

Therapy — The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

**Amino Acid-Based Elemental Formulas**

Coverage is provided for amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

1. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
2. Severe food protein-induced enterocolitis syndrome;
3. Eosinophilic disorders, as evidenced by the results of a biopsy; and
4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Coverage is required if the treating Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary for the treatment of a Covered Person who is diagnosed with a disease or disorder listed above. The Coverage must include any Medically Necessary services associated with the administration of the formula.

Coverage must also be provided no less favorable than the basis on which Prescription Drugs and other medications and related services are covered by the plan, and to the same extent that the plan provides coverage for drugs that are available only on the orders of a Physician.

**Autism**

Coverage is provided for screening a child for autism spectrum disorder at the ages of 18 and 24 months. Coverage is provided for autism spectrum disorder from the date of diagnosis until the Covered Person completes nine (9) years of age. However, if a child who is being treatment for autism spectrum disorder becomes ten (10) years of age or older and continues to need treatment, the treatment and services will continue.

Coverage is provided for all generally recognized services prescribed in relation to autism spectrum disorder by the primary care Physician in the treatment plan recommended by that Physician. However, coverage is not required for an individual ten (10) years of age or older for applied behavior analysis in an amount that exceeds 624 hours of care per year. An individual providing treatment prescribed must be a health care practitioner:

1. Who is licensed, certified, or registered by an appropriate agency of this state;
2. Whose professional credential is recognized and accepted by an appropriate agency of the United States;
3. Who is certified as a Provider under the TRICARE military health system; or
4. Who is an individual acting under the supervision of a health care practitioner as described above.

“Generally recognized services” may include services such as:

1. Evaluation and assessment services;
2. Applied behavior analysis;
3. Behavior training and behavior management;
4. Speech therapy;
5. Occupational therapy;
6. Physical therapy; or
7. Medications or nutritional supplements used to address symptoms of autism spectrum disorder.

**Cervical Cancer Screening**

Coverage is provided for an annual cervical cytological screening for women age eighteen (18) years or older for expenses for medically recognized diagnostic examination for the early detection of cervical cancer.

Coverage includes a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

A screening test required under this section must be performed in accordance with the guidelines adopted by:

1. The American College of Obstetricians and Gynecologists; or
2. Another similar national organization of medical professionals recognized by the commissioner.

**Chemical Dependency**

Coverage is provided for the necessary care and treatment of chemical dependency. Coverage for the necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a Hospital.
Definitions:
Chemical dependency means the abuse of, a psychological or dependence on, or an addition to alcohol or a controlled substance.
Chemical dependency treatment center means a facility that provides a program for the treatment of a chemical dependency under a written treatment plan approved and monitored by a Physician and that is affiliated with a Hospital under a contractual agreement for patient referral; accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Healthcare Organizations; licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or licensed, certified, or approved as a chemical dependency treatment program or center by another state agency.
Controlled substance means an abusable volatile chemical.

Child Immunizations
Coverage is provided for a family member of a Covered Person for each covered child from birth through the date of the child’s sixth birthday coverage for:

1. Immunization against:
   a) diphtheria;
   b) haemophilus influenzae type b;
   c) hepatitis B;
   d) measles;
   e) mumps;
   f) pertussis;
   g) polio;
   h) rubella;
   i) tetanus; and
   j) varicella; and

2. Any other immunization that is required for the child by law.

Clinical Trials
A “Qualified Individual” who is a Covered Person under the Policy and is in an approved clinical trial according to the trial protocol, with respect to the treatment of cancer or other life-threatening disease or Condition.
Coverage is provided for routine patient care costs for a “Qualified Individual” in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition (including cancer).

1) Trials funded by one (1) or more of the following:
   a) The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
   b) The National Institutes of Health;
   c) The Agency for Health Care Research and Quality;
   d) The Centers for Medicare & Medicaid Services;
   e) The United States Food and Drug Administration;
   f) The United States Department of Defense;

2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; and
3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs do not include:

1) The cost of an Investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
2) The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
3) The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4) A cost associated with managing a clinical trial; or
5) The cost of a health care service that is specifically excluded from coverage under a health benefit plan.

Colorectal Cancer Screening
Coverage is provided for colorectal cancer screening for any Covered Person who is fifty (50) years of age or older and at normal risk for developing colon cancer, for a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five (5) years; or a colonoscopy performed every ten (10) years.

Continuation of Coverage for Prescription Drugs
Coverage is provided for prescription drugs that were approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan’s drug formulary before the Policy’s renewal date.
Contraceptive Drugs and Devices and Related Services
Coverage is provided for oral contraceptives, contraceptive devices, and Outpatient contraceptive services, including a consultation, examination, procedure, or medical service that is provided on an Outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Pregnancy, Complications
Coverage is provided for Complications of Pregnancy the same as any other Sickness.

Developmental Delays
Coverage is provided for rehabilitative and habilitative therapies provided to a child and determined to be necessary to and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

Rehabilitative and habilitative therapies include:
(1) Occupational therapy evaluations and services;
(2) Physical therapy evaluations and services;
(3) Speech therapy evaluations and services; and
(4) Dietary or nutritional evaluations.

Diabetes
Coverage is provided for the equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item. Such equipment includes:
(1) Blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by or adapted for the legally blind;
(2) Test strips specified for use with a corresponding glucose monitor;
(3) Lancets and lancet devices;
(4) Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
(5) Insulin and insulin analog preparations;
(6) Injection aids, including devices used to assist with insulin injection and needleless systems;
(7) Insulin syringes;
(8) Biohazard disposal containers;
(9) Insulin pumps, both external and implantable, and associated appurtenances, which include:
   (A) insulin infusion devices;
   (B) batteries;
   (C) skin preparation items;
   (D) adhesive supplies;
   (E) infusion sets;
   (F) insulin cartridges;
   (G) durable and disposable devices to assist in the injection of insulin; and
   (H) other required disposable supplies;
(10) Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer’s warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
(11) Prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
(12) Podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
(13) Glucagon emergency kits.

Coverage is also provided for self-management training and education, including medical nutritional therapy. Diabetes self-management training shall be provided, or coverage for diabetes self-management training shall be provided to an insured or a caretaker, upon the following occurrences relating to an insured, provided that any training involving the administration of medications must comply with the applicable delegation rules from the appropriate licensing agency:
(1) The initial diagnosis of diabetes; in the care and management of that condition, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies;
(2) The written order of a Physician or practitioner indicating that a significant change in the symptoms or condition of the Insured requires changes in the Insured's self-management regime;
(3) The written order of a Physician or practitioner that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.

If the diabetes self-management training is provided on the written order of a Physician or other health care practitioner, including a health care practitioner practicing under protocols jointly developed with a Physician, the training must also include:
(1) A diabetes self-management training program recognized by the American Diabetes Association;
(2) Diabetes self-management training provided by a multidisciplinary team:
   (A) The non-Physician members of which are coordinated by:
      (i) A diabetes educator who is certified by the National Certification Board for Diabetes Educators; or
      (ii) An individual who has completed at least 24 hours of continuing
education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;

(B) That consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and

(C) Each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

(3) Diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or

(4) Diabetes self-management training that provides one or more of the following components:

(A) A nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;

(B) A pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

(C) A component provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or

(D) A component provided by a Physician.

Early Detection of Cardiovascular Disease
Coverage is provided for screening medical procedures to each Covered Person:

(1) Who is:

(A) A male older than forty-five (45) years of age and younger than seventy-six (76) years of age; or

(B) A female older than fifty-five (55) years of age and younger than seventy-six (76) years of age; and

(2) Who:

(A) Is diabetic; or

(B) Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.

Coverage is required to be provided under this section for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five (5) years, performed by a laboratory that is certified by a national organization recognized by the commissioner by rule for the purposes of this section:

(1) Computed tomography (CT) scanning measuring coronary artery calcification; or

(2) Ultrasonography measuring carotid intima-media thickness and plaque.

Emergency Care
Coverage is provided for the following coverage of emergency care. Emergency care means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Covered Person's Condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

(1) Placing the Covered Person's health in serious jeopardy;

(2) Serious impairment to bodily functions;

(3) Serious dysfunction of a bodily organ or part;

(4) Serious disfigurement; or

(5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Hearing Test
Coverage is provided for a covered child for:

(1) A screening test for hearing loss from birth through the date the child is thirty (30) days of age. No cost sharing will apply; and

(2) Necessary diagnostic follow-up care related to the screening test from birth through the date the child is twenty-four (24) months of age.

Coverage for a hearing test may be subject to a Copayment or Coinsurance requirement and may not be subject to a Deductible requirement or a dollar limit.

Loss of Impairment of Speech or Hearing
Coverage is provided for the necessary care and treatment of loss or impairment of speech or hearing.

Low Dose Mammography
Coverage is provided for women who is thirty-five (35) years of age or older for an annual screening by low-dose mammography for the presence of occult breast cancer.

Maternity Care
Coverage includes forty-eight (48) hours of Inpatient care following an uncomplicated vaginal delivery and ninety-six (96) hours of Inpatient care following an uncomplicated 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. It is not a requirement to:
(1) Give birth to a child in a Hospital or other Health Care Facility; or
(2) Remain under inpatient care in a Hospital or other Health Care Facility for any fixed term following the birth of a child.

**COVERAGE FOR POST DELIVERY CARE REQUIRED.**

(a) If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage required under Section 1366.055(a), a health benefit plan must provide to the woman and child coverage for timely post delivery care.

(b) The timeliness of the post delivery care shall be determined in accordance with recognized medical standards for that care.

(c) The post delivery care may be provided by a Physician, registered nurse, or other appropriate licensed health care provider.

(d) Subject to Subsection (e), the post delivery care may be provided at:
   (1) The woman’s home;
   (2) A health care provider’s office;
   (3) A health care facility; or
   (4) Another location determined to be appropriate under rules adopted by the commissioner.

(e) The coverage required under this section must give the woman the option to have the care provided in the woman’s home.

**Mental Illness – Crisis Stabilization and Residential Treatment for Children and Adolescents**

Coverage is provided for the treatment of mental or emotional illness or disorder for a Covered Person when the individual is confined in a Hospital and must also provide coverage for treatment in a residential treatment center for children and adolescent or a crisis stabilization unit that is at least as favorable as the coverage the plan provides for treatment of mental or emotional illness or disorder in a Hospital.

Each two (2) days of treatment is a crisis stabilization unit is the equivalent of one (1) day of treatment or mental or emotional illness or disorder in a hospital or inpatient program.

**Definitions:**

Crisis stabilization unit means a 24-hour residential program that provides, usually for a short term, intensive supervision and highly structured activities to individuals who demonstrate a moderate to severe acute psychiatric crisis.

**Minimum Stay for Mastectomy and Lymph Node Dissection**

Coverage is provided for the treatment of breast cancer for inpatient care for a minimum of:

(1) 48 hours following a mastectomy; and
(2) 24 hours following a lymph node dissection for the treatment of breast cancer.

We are not required to provide the minimum hours of coverage of inpatient care if the Covered Person and the Covered Person’s Physician determine that a shorter period of inpatient care is appropriate.

**Off-label Drugs**

Coverage is provided for any drug to treat an enrollee for a chronic, disabling, or life-threatening illness covered under the plan if the drug has been approved by the United States Food and Drug Administration for at least one indication, and is recognized by a prescription drug reference compendium or substantially accepted peer-reviewed medical literature.

**Orally Administered Anticancer Medication**

Coverage is provided for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on the same basis of other intravenously administered or injected cancer medications that are covered as medical benefits by the plan.

Prior authorization may be required for an orally administered anticancer medication. If an orally administered anticancer medication is authorized, the cost may not exceed the Coinsurance or Copayment that would be applied to chemotherapy or other cancer treatment visit.

**Osteoporosis, Detection and Prevention**

Coverage is provided for medically accepted bone mass measurements to detect low bone mass and to determine the enrollee’s risk of osteoporosis and fractures associated with osteoporosis.

**Phenylketonuria**

Coverage is provided for formulas necessary to treat phenylketonuria or a heritable disease the same as other drugs that are available only on the orders of a Physician.

“Heritable disease “ means an inherited disease that may result in mental or physical retardation or death.

“Phenylketonuria” means an inherited condition that, if not treated, may cause severe mental retardation.

**Prostate Cancer Screening**

Coverage is provided for an annual medically recognized diagnostic examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male who is at least fifty (50) years of age and is asymptomatic; or is at least forty (40) years of age and has a family history of prostate cancer or another prostate cancer risk factor.

**Prosthetic Devices**

Coverage is provided for prosthetic devices, orthotic devices, and professional
services related to the fitting and use of those devices. The covered benefits are limited to the most appropriate model of prosthetic or orthotic devices that adequately meets the medical needs as determined by the treating Physician or podiatrist and prosthetist or orthotist.

Coverage is subject to annual Deductibles, Copayments, and Coinsurance consistent with annual Deductibles, Copayments, and Coinsurance required for other coverage. Not subject to annual dollar limits.

Subject to Copayments and Deductibles, the repair and replacement of a prosthetic or orthotic device is a covered benefit unless the repair or replacement is necessitated by misuse or loss by the Insured.

Reconstructive Breast Surgery
Coverage is provided for all stages of reconstructive of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.

Reconstructive Surgery for Craniofacial Abnormalities
Coverage is provided for reconstructive surgery for craniofacial abnormalities. "Reconstructive surgery for craniofacial abnormalities" means surgery to improve the function of or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Telemedicine Medical Service or a Telehealth Service
Coverage is provided on the same basis for telemedicine medical service or a telehealth service as a face-to-face consultation. The amount of the Deductible, Copayment, or Coinsurance may not exceed the amount required for a comparable medical service provided through a face-to-face consultation.

Temporomandibular Joints (TMJ)
Coverage is provided for the diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is Medically Necessary as a result of:
1. An accident;
2. A trauma;
3. A congenital defect;
4. A developmental defect; or
5. A pathology.

Coverage may be subject to any provision that is generally applicable to surgical treatment, including a requirement for Pre-Authorization of coverage.

COORDINATION OF BENEFITS
The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

SUBROGATION AND RECOVERY RIGHTS
When We pay benefits under the Policy and it is determined that a negligent third party is liable for the same expenses, We have the right to subrogate from the monies payable from the negligent third party equal to the amount We have paid for such expenses. The Insured hereby agrees to reimburse Us from any monies recovered from a negligent third party as a result of a judgment against, settlement with, or otherwise paid by the third party. The Insured agrees to take action against the third party, furnish all information, and provide assistance to Us regarding the action taken, and execute and deliver all documents and information necessary for Us to enforce our rights of subrogation.

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. Vaccines and immunizations (except as specifically provided in the Policy): a) required for travel; and b) required for employment.
3. 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, shoe inserts and Orthotic Device; except for treatment of Injury, infection or disease.
4. Cosmetic treatment cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies furnished primarily to improve appearance rather than a physical function or control of organic disease except for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; warts, non-malignant moles and lesions; hair
growth; hair removal; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants, including gynecomastia, (except for correction or deformity resulting from mastectomies or lymph node dissections); lipectomy services and supplies related to surgical suction assisted lipectomy; rhinoplasty; nasal and sinus surgery; and deviated nasal septum, including submucous resection except when Medically Necessary treatment of acute purulent sinusitis. This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part.

5. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by the person’s Attending Physician or dentist.

6. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications.

7. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein or except an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Covered Person’s Physician or by the dentist providing the dental care).

8. Injury occurring in consequence of riding as a passenger or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline or as a passenger in a Policyholder owned leased chartered or operated aircraft or as a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.

9. Reproductive/Infertility services, including but not limited to: family planning treatment of infertility (male or female) including medication, surgery, supplies, and fertilization procedures rendered for the purpose or with the intent of inducing conception; premarital examination; impotence, organic or otherwise; sterilization reversal; vasectomy; vasectomy reversal except as specifically provided in this Policy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, artificial insemination, embryo transfer or similar procedures that augment or enhance Your reproductive ability.

10. Elective termination of pregnancy.

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

12. Services for the treatment of any Injury or Sickness incurred while committing a felony; or while participating in a riot; or fighting, except in self-defense.

13. Injury or Sickness for which Benefits are paid or payable under any workers’ compensation or occupation disease law or act, or similar legislation.

14. War or any act of war, declared or undeclared; or while in the armed forces of any country.

15. Obesity treatment: Services and associated expenses for the treatment of obesity, except nutrition counseling specifically provided in the Policy, and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:
   - Gastric or intestinal bypasses;
   - Gastric balloons;
   - Stomach stapling;
   - Wiring of the jaw;
   - Panniculectomy;
   - Appetite suppressants;
   - Surgery for removal of excess skin or fat.


17. Diagnosis and treatment of sleep disorders including but not limited to apnea monitoring, sleep studies, and oral appliances used for snoring, except treatment and appliances for documented obstructive sleep apnea.

18. Elective Treatment, except as specified in the Schedule of Benefits.

19. Exclusions do not apply to injuries related to an act of domestic violence.
CLAIM PROCEDURES

In the event of either an Injury or a Sickness:
1. Report to their Physician, Hospital or the Stephen F Austin State 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: S214916

CLAIMS APPEAL PROCESS

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person may request an appeal in writing within one hundred eighty (180) days of the date appearing on the EOB. The appeal request must include why the Insured Person disagrees with the way the claim was processed. The request must include any additional information he/she feels supports the request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator, Consolidated Health Plans.

This plan is underwritten by:
Nationwide Life Insurance Company
Columbus, OH
Policy Number: 302-010-4214

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 Company. 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.