Student Health Insurance Plan

Designed for the Students of

GRINNELL COLLEGE

2016-2017

Underwritten by:

Nationwide Life Insurance Company
Columbus, OH

Policy Number: 302-004-1414
Group Number: S214616

Effective Date: 8/14/2016
Policy Anniversary Date: 8/13/2017

Administered by:

CHP Student

Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

TABLE OF CONTENTS

WHERE TO FIND HELP

For Questions About:	Please Contact:
Enrollment Services	www.chpstudent.com Please select Grinnell College from the drop down box and proceed as directed to enroll in the student health insurance plan.
Insurance Benefits Preferred Provider Listings Claims Processing Id Card Requests	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 www.chpstudent.com
Preferred Provider Listings	**First Health** **www.firsthealthlbp.com**
Find a Prescription Drug Provider:	OptumRx Pharmacy Network (800) 248-1062 **www.optumrx.com**

AM I ELIGIBLE?

All full time students are required to have insurance. You are automatically enrolled in the plan at the time of registration and the premium amount is added to your student account.

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.

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.

Students who can provide proof of comparable coverage may Waive participation in this plan.
Waiver Deadlines:

- Fall Semester: 8/25/2016

Dependents are not eligible under this plan.

INVOLUNTARY LOSS OF OTHER COVERAGE

If You are eligible for Coverage but do not enroll in Coverage under this Policy when You first meet the definition of Eligible Person as a result of coverage under another Policy, You may be eligible to enroll in Coverage under this Policy provided enrollment and Premium are received within thirty-one (31) days of Involuntary Loss of Other Coverage.
For purposes of this section, Involuntary Loss of Other Coverage means that prior coverage is involuntarily terminated due to no fault of the Eligible Person, which includes coverage that terminates due to a loss of employment by the Eligible Person or the Eligible Person's spouse or parent. This definition does not include coverage that has a predetermined termination date, or expiration of COBRA eligibility, and does not apply to coverage that has been voluntarily terminated.
Coverage is effective upon enrollment and receipt of Premium by Us or Our authorized representative.

EFFECTIVE DATES AND COSTS

	Annual* 08/14/16 – 08/13/17	**Spring * 01/14/17 – 08/13/17**
Student	$1,516	$881

**The above rates include an administrative fee.*

TERMINATION OF BENEFITS

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

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the Covered Person's Termination Date. However, if a Covered Person is Hospital Confined Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of ninety (90) days or until date of discharge, whichever is earlier.

The total payments made in respect of the Insured for such Condition both before and after the Termination Date will never exceed the Maximum Benefit. After this Extension of Benefits provision has been exhausted, all Benefits cease to exist and under no circumstances will further Benefits be made.

This Extension of Benefits provision is applicable only to the extent the Covered Person will not be covered under this or any other similar health insurance policy in the ensuing term of Coverage. Dependents that are newly acquired during the Insured's Extension of Benefits period are not eligible for Benefits under the provision.

DEFINITIONS

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

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

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

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.

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

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

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

Covered Person: A person:

- Who is eligible for Coverage as the Insured;
- Who has been accepted for Coverage or has been automatically added;

- For whom the required Premium has been paid; and
- Whose Coverage has become effective and has not terminated.

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

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

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of Covered Services: ambulatory patient services; Emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; Rehabilitative and Habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

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

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

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

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

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.

Morbid Obesity: A body mass index that is greater than 40 kilograms per meter squared; or, equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

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

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

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

Out-of-Pocket Maximum: 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 and non-covered and Elective Treatment do not count toward this limit.

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

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

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

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

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

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.

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

(a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

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

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

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

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

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

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

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

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

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.

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

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

SCHEDULE OF BENEFITS

Actuarial Value: 90.93%

Equivalent or next lowest coverage level: Platinum

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

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

EFFECTIVE DATE: 08/14/2016 **TERMINATION DATE**: 08/13/2017

Policy Year Maximum Benefit		
Insured	unlimited	
	In-Network Benefit	**Out-of-Network Benefit**
Deductible (except as specified herein) per Policy Year, per Covered Person, Benefits are subject to Deductible unless otherwise indicated. The Deductible shall not apply: o In-Network Preventive/wellness exams and immunizations; o In-Network Office Visits; o In-Network Outpatient Prescription drugs; • Copayments do not apply to Deductibles.	$100	$350
Insured Percent (except as specified herein) ***Special Provider (SHC) – 100% of charges incurred.***	90% of Preferred Allowance (PA)	70% of Reasonable & Customary (R&C)
Out-of-Pocket Maximum per Covered Person. • Includes Coinsurance, Copayments and Deductibles; • Excludes non-covered medical expenses and Elective Treatment; • Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year; • Once the Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network; • Once the Out-of-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% Out-of-Network. • An individual Covered Person's Out-of-Pocket Maximum will never exceed $2,000 (In-Network) per Policy Year as part of the listed Family Out-of-Pocket Maximum.	$2,000	$6,000
Covered Charges – Essential Health Benefits	**In-Network Benefit**	**Out-of-Network Benefit**
Preventive Care (See Definition for additional information.)		
Preventive Services	100% of PA Deductible waived	Not Covered

Outpatient Services - (other than Surgery and Maternity)		
Office Visits, performed and billed by a Physician's office, including Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician. Limited to (one) 1 visit per day.	100% of PA after a $10 Copayment per visit+ waiver of Deductible	70% of R&C after a $10 Copayment per visit
Specialist Office Visit	100% of PA after a $10 Copayment per visit + waiver of Deductible	70% of R&C after a $10 Copayment per visit
Consulting Physician - Limited to (one) 1 visit per day.	100% of PA after a $10 Copayment per visit + waiver of Deductible	70% of R&C after a $10 Copayment per visit
Diagnostic Imaging - Includes x-ray services which are diagnostic or therapeutic.	90% of PA	70% of R&C
Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.	90% of PA	70% of R&C
CT Scan, MRI, and /or PET Scans	90% of PA	70% of R&C
Infusions (done in an Outpatient Health Care Facility or Physician's office)	90% of PA	70% of R&C
Injections (done in an Outpatient Health Care Facility or Physician's office)	90% of PA	70% of R&C
Radiation	90% of PA	70% of R&C
Chemotherapy	90% of PA	70% of R&C
Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - Includes administration and supplies.	90% of PA	70% of R&C
Inpatient Services – (other than Surgery and Maternity)		
Miscellaneous Hospital Services	90% of PA	70% of R&C
Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital.	90% of PA	70% of R&C
Intensive Care Room	90% of PA	70% of R&C

Physician visit, during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility. Limited to (one) 1 visit per day.	90% of PA	70% of R&C
Specialist visit	90% of PA	70% of R&C
Consulting Physician, when requested and approved by the Attending Physician. Limited to (one) 1 visit per Consulting Physician per day.	90% of PA	70% of R&C
Skilled Nursing Facility and Sub-Acute Care Facility - Includes semi-private room and board, general nursing services, meals and prescribed diets, supplies, Diagnostic Imaging, laboratory, Rehabilitation.	90% of PA	70% of R&C
Inpatient Rehabilitation Facility - Includes Physical Therapy, occupational therapy, Restorative Speech Therapy, cardiac therapy, and pulmonary therapy which is expected to result in significant return of function.	90% of PA	70% of R&C
Surgical Services		
When multiple surgeries are performed through the same incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. When multiple surgeries are performed through more than one (1) incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. The Benefit for the primary or most expensive procedure or less expensive procedures is 50% of the Benefit otherwise payable for each subsequent procedure.		
Inpatient Surgical Services		
Surgeon	90% of PA	70% of R&C
Assistant Surgeon	90% of PA	70% of R&C
Anesthetist Services	90% of PA	70% of R&C
Inpatient Surgical Miscellaneous - Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	90% of PA	70% of R&C
Outpatient Surgical Services		
Surgeon	90% of PA	70% of R&C
Assistant Surgeon	90% of PA	70% of R&C
Anesthetist Services	90% of PA	70% of R&C

Outpatient Surgical/Day Surgery Miscellaneous - Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.	90% of PA	70% of R&C
Other Surgical Services (Inpatient/Outpatient)		
General Anesthesia for Dental services	90% of PA	70% of R&C
Reconstructive Surgery	90% of PA	70% of R&C
Organ Transplant Surgery - Coverage is provided for bone marrow, stem cell, heart, lung, heart and lung, kidney, pancreas, kidney and pancreas, liver and colon transplants only.	90% of PA	70% of R&C
Morbid Obesity Surgery	90% of PA	70% of R&C
Reproductive Services		
Maternity Care – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, a follow-up Home Health Care visit will be provided.		
Pre- and Post-Natal Care, except diagnostic services performed and billed by a Physician's office, delivery and Inpatient Physician visits for mother and baby.	Paid as any other Sickness	Paid as any other Sickness
Diagnostic services performed and billed by a Physician's office, including ultrasounds and amniocentesis.	Paid as any other Sickness	Paid as any other Sickness
Other Reproductive Services		
Medically Necessary Termination of Pregnancy	90% of PA	70% of R&C
Injected or Implanted Contraceptives (Oral Contraceptive coverage is included in the Prescription Drug coverage).	100% of PA + waiver of Deductibles & Copayments	70% of R&C
Infertility Services – diagnosis **only**	90% of PA	70% of R&C

Voluntary Male Sterilization Surgery (***Excludes sterilization reversal).*** **Note:** Sterilization procedures for women are covered under Preventive Care.	90% of PA	70% of R&C
Biologically Based Mental Illness/Mental Conditions and Alcoholism/Drug Use		
Inpatient services - including Alcoholism/Drug detoxification.	Paid as any other Sickness	Paid as any other Sickness
Outpatient Office Visits - Includes partial, residential or day treatment.	Paid as any other Sickness	Paid as any other Sickness
Urgent Care and Emergency Services		
Urgent Care Facility (non Emergency) services **Note:** The Copayment amount for this visit is waived if You are admitted to a Hospital.	100% of PA after a $150 Copayment per visit + waiver of Deductible	100% of R&C after a $150 Copayment per visit+ waiver of Deductible
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. • Copayment waived if admitted to Hospital • Follow-up care at the Emergency room is not covered.	100% of PA after a $150 Copayment per visit + waiver of Deductible	100% of R&C after a $150 Copayment per visit + waiver of Deductible
Emergency Medical Transportation services	90% of PA	70% of R&C
Other Services		
Allergy Testing	90% of PA	70% of R&C
Allergy Injections/treatment - Includes treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments. Also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.	90% of PA	70% of R&C

Clinical Trials - Includes coverage for routine patient costs associated with a Covered Person's participation in a clinical trial. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care of the Covered Person.	90% of PA	70% of R&C
Habilitative Care – for congenital disorders and developmental delays, only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, occupational therapy, and Speech Therapy for a function that did not previously exist, but would normally be expected to exist.	90% of PA	70% of R&C
Rehabilitative Care - only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, Occupational Therapy, Restorative Speech Therapy, and cardiac rehabilitation which is expected to result in significant return of function. Limited to (one) 1 visit per day.	90% of PA	70% of R&C
Pulmonary Therapy	90% of PA	70% of R&C
Respiratory Therapy	90% of PA	70% of R&C
Chiropractic care - Includes x-rays, office visits, laboratory services, manipulations and modalities (i.e., hot packs, cold packs and ultrasounds, etc.), regardless of Provider type. Limited to (one) 1 visit per day.	90% of PA	70% of R&C
Dermatology	90% of PA	70% of R&C
Home Health Care services	90% of PA	70% of R&C
Hospice	90% of PA	70% of R&C
Diabetic Treatment and Education	90% of PA	70% of R&C

Durable Medical Equipment (DME) - (Includes Prosthetic and Orthotic Devices). Excludes foot orthotics, except as related to complications from Diabetes. ***Note: No Deductible is applied for In-Network Prosthetic limbs.***	90% of PA after a $50 Copayment per prescription	70% of R&C after a $50 Copayment per prescription
Dental Treatment due to Accidental Injury to a Sound Natural Tooth.	90% of PA	70% of R&C
Removal of an impacted or abscessed tooth - Covered only when a medical condition that requires hospitalization for the removal is present.	90% of PA	70% of R&C
Sleep Apnea - Includes coverage for the diagnosis and treatment of obstructive sleep apnea only.	90% of PA	70% of R&C
TMJ - treatment for the dysfunction of the temporomandibular joints, including surgery of the jaw to correct or treat TMJ. Does not include dental extractions, restorations, appliances or orthodontic treatment related to temporomandibular joint disorders.	90% of PA	70% of R&C
Genetic testing for diagnostic purposes only.	90% of PA	70% of R&C
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.		
Preventive Dental – preventive & diagnostic services, for Covered Persons under the age of nineteen (19). Limited to 1 exam / prophylaxis every 6 month. Includes: • Topical fluoride treatment – 2 per 12 months • x-rays – bitewing – 1 set per 6 months • x-rays - full-mouth and panoramic – 1 per 60 months • sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months) • space maintainers		100% of R&C

Pediatric Dental – basic restorative services, for Covered Persons under the age of nineteen (19). Includes: • emergency palliative treatment of pain • fillings (amalgam, resin-based composite) • prefabricated stainless steel crown – 1 per tooth per 60 months • endodontics - therapeutic pulpotomy • periodontics - scaling and root planning, limited to 1 every 24 months • prosthodontics – denture repair, denture rebase/reline (1 per 36 months; 6 months after initial installation) • Oral surgery	70% of R&C
Pediatric Dental – major services, for Covered Persons under the age of nineteen (19). Includes: • prosthodontics - crowns, bridges, and dentures - 1 per tooth/arch every 60 months • endodontics (root canals on permanent teeth limited to one per tooth per lifetime) • periodontics – gingivectomy or gingivoplasty, limited to 1 every 36 months • general anesthesia and IV sedation – in conjunction with complex oral surgery	50% of R&C
Pediatric Dental – Medically Necessary orthodontia services *, for Covered Persons under the age of nineteen (19) with severe and handicapping malocclusion. Includes: • pre-orthodontic treatment • orthodontic treatment • appliance therapy • orthodontic retention *Requires pre-authorization	50% of R&C
Routine Vision Exam for Covered Persons under the age of nineteen (19). Includes: • 1 exam/fitting per Policy Year, including dilation if professionally indicated • prescription eyeglasses (lenses and frames), or one (1) year supply of contact lens in lieu of eyeglasses, limited to once per Policy Year	100% up to $150, then 50% thereafter

• 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.	

Outpatient Prescription Drugs

Retail Prescription Drugs - per prescription or refill, subject to dispensing limits.
Note: Retail Prescription Drugs will be considered an Essential Health Service unless prescribed drug is related to an Elective Treatment, subject to exclusions and other limitations of the Policy.

The Pharmacy Benefits Manager (PBM) is: Optum

4 Tier Plan	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
1. Generic Drugs	100% of R&C after a $15 Copayment	Not Covered
2. Preferred Brand Drugs	100% of R&C after a $30 Copayment	Not Covered
3. Non-Preferred Brand Drugs	100% of R&C after a $30 Copayment	Not Covered
4. Specialty Drugs	100% of R&C after a $30 Copayment	Not Covered

- Only a thirty (30) day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy).
- One (1) Copayment per thirty (30) day supply. No cost sharing applies to Generic Contraceptives and other applicable Preventive Care drugs.
- Includes prescription contraceptives which have been approved by the FDA, prescribed pre-natal vitamins, and smoking deterrent prescription medications.
- Includes medications, equipment and supplies for the management and treatment of diabetes.
- The Deductible does ***not*** apply.
- The Covered Person will be responsible for the cost difference between Brand and Generic, in addition to the Tier 2, 3 Copayment for a Brand drug when there is a Generic equivalent available unless "Do Not Substitute" or "Dispense as Written" is indicated on the prescription.

Covered Charges – Elective Treatment Please note – all benefits are per Policy Year, unless otherwise noted.	In-Network Benefit	Out-of-Network Benefit
Elective Treatment		
Private Duty Nursing Care	90% of PA	70% of R&C
Gender reassignment Surgery – up to $25,000 maximum per Policy Year.	90% of PA	70% of R&C
Intramural & Club Sports	Paid as any other Injury	Paid as any other Injury
Non-emergency coverage outside of the United States, if not covered by any other coverage. **Maximum Benefit:** $20,000 per Policy Year.	70% of actual charges	

MANDATED BENEFITS

Benefits subject to applicable Deductible, Coinsurance, and Copayments as outlined in the Schedule of Benefits. Note: Wellness/Preventive Benefits under the Affordable Care Act (ACA) are required to meet federal regulations; no cost sharing will apply to these benefits for In-Network services. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate.

Clinical Trials
Contraceptives
Dental Anesthesia
Diabetes Treatment
Prosthetics
Reconstructive Breast Surgery

SUBROGATION AND RECOVERY RIGHTS

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

EXCESS PROVISION

No benefits are provided by the Policy for expenses which are reimbursable by other valid and collectible insurance plan, but such charges in excess thereof shall be covered as otherwise provided.

EXCLUSIONS

Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

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

1. Eyeglasses, contact lenses, routine eye refractions, eye examinations except as in the case of Injury prescriptions or fitting of eyeglasses or contact lenses vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.
2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids and the fitting or repairing or replacement of hearing aids, except in the case of Accident or Injury.
3. Vaccines and immunizations (except as specifically provided in the Policy): a) required for travel; and b) required for employment.
4. Treatment (other than surgery) of chronic Conditions of the foot including weak feet, fallen arches, flat foot, pronated foot, subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions (except capsular or bone surgery), any type of massage procedure on or to the foot, corrective shoes, and shoe inserts.
5. Cosmetic treatment cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; 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.

6. 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.
7. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications.
8. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein).
9. Long-term care.
10. Injury sustained while (a) participating in any, intercollegiate, professional, semi-professional or contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition.
11. Injury sustained by reason of a motor vehicle Accident to the extent that Benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such Benefits or if the Insured is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place. This exclusion will not apply to passengers if they are insured under the Policy.
12. 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.
13. Reproductive/Infertility services except for diagnosis including but not limited to: family planning treatment of infertility (male or female) medication, surgery, supplies, and fertilization procedures rendered for the purpose or with the intent of inducing conception premarital examination; impotence, organic or otherwise; sterilization reversal; vasectomy reversal 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.
14. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee.
15. Telemedicine.
16. Under the Prescription Drug Benefit, any drug or medicine:
    - Obtainable Over the Counter (OTC);

    - for the treatment of alopecia (hair loss) or hirsutism (hair removal);
    - for the purpose of weight control;
    - anabolic steroids used for body building;
    - for the treatment of infertility;
    - sexual enhancement drugs;
    - cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in this Policy;
    - treatment of nail (toe or finger) fungus;
    - refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
    - for an amount that exceeds a 30 day supply
    - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
    - purchased after Coverage under the Policy terminates;
    - consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is:
        i. contraindicated for the treatment of the Condition for which the drug was prescribed; or
        ii. Experimental for any reason.
17. Services for the treatment of any Injury or Sickness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot; or fighting, except in self-defense.
18. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
19. War or any act of war, declared or undeclared; or while in the armed forces of any country.
20. Obesity treatment (*except in the case of Morbid Obesity*): 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; and surgery for removal of excess skin or fat.
21. Acupuncture.
22. 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.
23. Elective Treatment, except as specified in the Policy.

CLAIM PROCEDURES

In the event of Injury or Sickness, students should:

1. Report to their Physician, Hospital or 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.

CLAIM APPEAL PROCESS

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person must request an appeal in writing within 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.

The Plan is Underwritten By:
Nationwide Life Insurance Company
Columbus, OH
Policy Number: 302-004-1414

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800-633-7867
Email: customerservice@consolidatedhealthplan.com
www.chpstudent.com
S211416

Servicing Broker:
SAS/Ryan Desch
651-439-7098
Email: ryand@sas-mn.com

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

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

Representations of this plan must be approved by the Company.

VALUE ADDED SERVICES

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

***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.

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.