

Student Health Insurance
Designed for the Students of
Eastern Washington University
(International Students)

2015-2016

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH

Policy Number: 302-004-4613
Effective: 09/17/2015 to 09/16/2016
Group Number: S213915

IMPORTANT DISCLOSURE:

This is the final version of Your health coverage policy. This policy form supersedes any previous version of this policy You have received. Please discard any previous versions of this policy.

To find out whether the care you need is covered, please call Consolidated Health Plans at 1-800-633-7867 or email us at customerservice@consolidatedhealthplan.com.

At all times you are covered under this policy, all of the benefits to which you are entitled will be provided according to Washington and Federal law, even if this version of your policy form says something different.

IMPORTANT NOTICE

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

NONDISCRIMINATORY

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

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WHERE TO FIND HELP

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

For Questions About:	Please Contact:
Waiver Process Health Services	Wells Fargo Insurance (800) 853-5899 studentinsurance.wellsfargo.com
Enrollment Dependent Enrollment	Wells Fargo Insurance (800) 853-5899 studentinsurance.wellsfargo.com
Insurance Benefits Preferred Provider Listings Claims Processing	Consolidated Health Plans 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 www.chpstudent.com
Preferred Provider Listings	PHCS www.phcs.com
Prescription Drug Benefit & Providers	Cigna PBM www.cigna.com

AM I ELIGIBLE?

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

All International students are automatically enrolled unless You can certify that You have comparable coverage.

Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium, minus any claims paid.

HOW DO I WAIVE?

All international students enrolled in six or more credit hours are automatically enrolled in the Eastern Washington University Student Health Insurance Plan at registration. The insurance can be waived if proof of valid comparable insurance is furnished.

To waive the Student Health Insurance Plan, visit <http://access.ewu.edu/health-and-wellness/health-services/international-student-health-insurance> by the waiver deadlines posted below.

Deadline to Waive Coverage:

- **Fall 2015 – October 1, 2015**
- **Winter 2016 – January 12, 2016**
- **Spring 2016 – April 6, 2016**
- **Summer 2016 – June 29, 2016**

COVERAGE FOR DEPENDENTS

Insured Students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents. Eligible dependents under the plan include the Insured person’s spouse and dependent children under age twenty-six (26). Dependent Eligibility expires concurrently with that of the Insured Student.

Students may also enroll their Dependents within sixty (60) days of an eligible qualifying event. Eligible qualifying events for a Dependent are defined in the Master Policy. Enrollment requests (including payments) received after the sixty (60) days following the qualifying event will not be accepted. Coverage will be effective as of the date of the qualifying event.

EFFECTIVE DATES AND COSTS

The Eastern Washington University International Student Health Insurance Plan provides coverage to students for a twelve (12) month period - from 12:01 a.m. **September 17, 2015, through September 16, 2016.**

Please contact Consolidated Health Plans at 1-800-633-7867 or email us at customerservice@consolidatedhealthplan.com for information regarding the cost of this plan.

TERMINATION

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

- The Termination Date of the Policy;
- The date the Insured ceases to an Eligible Person (see Premium Refund section for details);
- The last day of the term of Coverage for which Premium is paid;
- The date a Covered Person enters full time active military service. Upon written request within sixty (60) days of leaving school, We will refund the unearned pro-rata Premium to such person upon written request.
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined.
- The date the Covered Person departs the Policyholder's school for their Home Country permanently. No Benefits will be payable for any medical treatment received in the Covered Person's Home Country.

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the termination date, shown on the face page. However, if a Covered Person is Hospital Confined on the Termination Date 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 thirty (30) days or until date of discharge, whichever is earlier.

The total payments made in respect of the Covered Person 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.

Dependents that are newly acquired during the Insured's Extension of Benefits period are not eligible for Benefits under the provision.

PREMIUM REFUND POLICY

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

Any Insured withdrawing from school must submit documentation or certification of the medical withdrawal to Us at least thirty (30) days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or thirty (30) days after the start date of the medical leave of absence from school, 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.

PRE-CERTIFICATION PROCESS

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

Failure to comply with the Pre-Certification process requirements will result in a Pre-Certification penalty. Such penalty amount is payable even though Deductible and Out-of-Pocket Maximum amounts have been met. The Pre-Certification penalty is listed in the Schedule of Benefits.

You are responsible for calling the Review Organization at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services or surgery, the call must be made at least five (5) working days prior to Hospital Confinement or surgery. In the case of an Emergency, the call should take place within two (2) working days of admission or as soon as reasonably possible.

Pre-Certification is not required for Medical Emergency or Hospital Confinement for maternity care.

Pre-Certification is not required for a Covered Person receiving mental health care and treatment rendered by a state hospital if the Covered Person is involuntarily committed to a state hospital.

The following Inpatient and Outpatient services or supplies require Pre-Certification:

- All Inpatient admissions, including length of stay, to a Hospital, convalescent facility, Skilled Nursing Facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility;
- All Inpatient maternity care after the initial 48/96 hours;
- All partial hospitalization in a Hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse;
- Surgery.

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

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

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

Our Review Organization agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non urgent requests following receipt of all necessary information for review. In no event will the review period extend beyond twenty (20) working days with regard to Experimental or Investigational treatments except with the informed, written consent of the Covered Person. Notice of an adverse determination made by the Review Organization agent will be in writing and will include:

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

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

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

PRE-ADMISSION NOTIFICATION

Pre-Notification of Medical Non-Emergency Hospitalizations:

The Covered Person, Physician or Health Care Facility must call the toll free telephone number on the back of the Identification Card at least five (5) working days prior to the planned admission.

Notification of Medical Emergency Admissions:

The Covered Person, Physician, Covered Person's representative, or Health Care Facility should call the toll free telephone number on the back of the ID card within two (2) working days of the admission to provide notification of any admission due to Medical Emergency.

Important: Failure to follow the notification procedure will not affect Benefits otherwise payable under the Policy. However, failure to follow the pre-notification procedures will result in the Pre-Notification penalty listed in the Schedule of Benefits. Pre-notification is not a guarantee that Benefits will be paid.

MANDATED BENEFITS

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

Anesthesia for Dental Services - Coverage is provided for general anesthesia services and related facility charges in conjunction with any dental procedure performed in a Hospital or Ambulatory Surgical Center if such anesthesia services and related facility charges are Medically Necessary because the Covered Person:

- (a) (a) Is under the age of seven (7), or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
- (b) Has a medical condition that the Covered Person's Physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Covered Person's Physician.

"General anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

Chemical Dependency - Coverage is provided for treatment of chemical dependency in an approved treatment facility program.

"Chemical Dependency" means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

"Approved treatment program" means a discrete program of chemical dependency treatment provided by a treatment program certified by the department of social and health services.

Colorectal Cancer Screening - Coverage is provided for colorectal cancer examinations and laboratory tests consistent with the recommendation of the U.S. preventive services task force or the federal centers for disease control and prevention. Benefits include:

- (a) For any of the colorectal screening examinations and tests in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the patient's Physician after consultation with the patient; and
- (b) To a covered individual who is:
 - At least fifty (50) years old; or
 - Less than fifty (50) years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.

Congenital Anomalies in Children and Newborns - Coverage is provided for newborn infant children from and after the moment of birth, subject to eligibility. Coverage provided includes, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

Contraceptive Coverage - Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other Outpatient services.

Diabetes- Coverage is provided for the following services and supplies for Covered Persons with diabetes:

- Coverage for pharmacy services, appropriate and Medically Necessary equipment and supplies, as prescribed by a health care Provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and
- Outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care Provider. Diabetes outpatient self-management training and education may be provided only by health care Providers with expertise in diabetes.

Home Health Care and Hospice Care - Coverage is provided for Hospice care coverage for terminally ill patients for an initial period of care of not less than six (6) months and may provide benefits for an additional six (6) months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the Attending Physician.

Coverage is provided for Home Health Care benefits for at least a minimum of one hundred thirty (130) health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one (1) visit.

Mammography - Coverage is provided for the screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's Physician or advanced registered nurse practitioner or physician assistant.

Mental Health Treatment - Coverage is provided for Mental Health Treatment and Prescriptions the same any other Illness. "Mental Health Treatment" means Medically Necessary Outpatient and Inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) Skilled Nursing Facility services, Home Health Care, residential treatment, and custodial care; and (d) court ordered treatment unless the insurer's medical director or designee determines the treatment to be Medically Necessary.

Phenylketonuria Treatment - Coverage is provided for the formulas necessary for the treatment of phenylketonuria.

Prenatal Testing for Congenital Disorders - Coverage is provided for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy to such enrollees when those services are determined to be Medically Necessary by the disability contractor in accord with standards set in rule by the board of health.

Prostate Cancer Screening - Coverage provided for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's Physician, advanced registered nurse practitioner, or Physician assistant.

Reconstructive Breast Surgery - Coverage is provided for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury. Including but not limited to:

- All stages of one (1) reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.
- Mastectomy bras; The Covered Person must be given reasonable access to a number of bras including replacement due to usage;
- For prostheses and physical complications including lymphedemas;
- Coverage may not be denied because of a mastectomy or lumpectomy performed on the Covered Person more than five (5) years previously.

Self-administered Anticancer Medications - Coverage is provided for prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis at least comparable to cancer chemotherapy medications administered by an approved health care Provider or facility.

Temporomandibular Joint Disorder - Coverage is provided for medical services related to the treatment of temporomandibular joint disorders (TMJ).

DEFINITIONS

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

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

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.

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.

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:

- Legally married spouse, who is not legally separated from the Insured and resides with the Insured;
- Child who is under the age of twenty-six (26).

The term child refers to the Insured's:

- Natural child;
- Stepchild; A stepchild is a Dependent on the date the Insured marries the child's parent.
- 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.
- Foster child is a Dependent from the moment of placement with the Insured as certified by the agency making the placement.

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.

Emergency: An Illness, Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid severe harm.

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).

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.

Injury: Bodily Injury due to a sudden, unforeseeable, external event which results independently of disease, bodily infirmity or any other causes.

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.

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

Covered Services are Medically Necessary if they are:

- Required to meet the health care needs of the Covered Person; and
- Consistent (in scope, duration, intensity and frequency of treatment) with current scientifically based guidelines of national medical or research organizations or governmental agencies; and
- Consistent with the diagnosis of the Condition; and
- Required for reasons other than the comfort or convenience of the Covered Person or Provider; and
- Of demonstrated medical value and medical effectiveness.

A Covered Service is Medically Appropriate if it is rendered in the most cost-effective manner and type of setting appropriate for the care and treatment of the Condition.

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

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

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

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

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.

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.

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.
- (e) Chronic disease management services, which include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple Providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools.

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 (Sick): means 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.

We, Our and Us: Nationwide Life Insurance Company.

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

Male pronouns whenever used include female pronouns.

PREFERRED PROVIDER INFORMATION

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

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

If care is received within the Network from a Preferred Provider, all Covered Medical Expenses will be paid at the Preferred Provider level of benefits found on the Schedule of Benefits. In the case of an Emergency, if an Out-of-Network Provider is used, the In-Network percentage in the Schedule of Benefits will be applied.

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

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

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

COORDINATION OF BENEFITS

The Policy Year is the basis for consideration of claims. This provision will be used when the Benefits the Covered Person would receive under this Policy plus those received under all other Plans would exceed the total Allowable expense. If the

Benefits provided under all Plans exceed the Allowable expense, We will reduce Our Benefits so that the total benefit received from all plans does not exceed 100% of Allowable expenses. When Benefits are reduced under the primary plan because the Covered Person did not comply with the plan provisions, the amount of such reduction will not be considered an Allowable expense.

SUBROGATION AND RECOVERY RIGHTS

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

EXCLUSIONS

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

1. Eyeglasses, contact lenses, routine eye refractions, eye examinations, prescriptions or fitting of eyeglasses or contact lenses (except as in the case of Injury or as provided); vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except when due to a disease process; except eye refractions, performed by a Physician or optometrist, when used as a diagnostic tool in conjunction with a chronic or acute medical Condition. Repair or replacement of eye glasses or contact lens except when required as a direct result of an Injury.
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, shoe inserts and Orthotic Device; except for treatment of Injury, infection or disease or as provided herein.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that are to be furnished primarily to improve appearance rather than a physical function or control of organic disease except as provided herein or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; 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 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. Upon written request, claims denied under this provision may be reviewed by an independent medical review entity if You has a terminal Condition that, according to the Physician's current diagnosis, has a high probability of causing death within two (2) years from the date of the request for medical review.
8. Custodial Care; long-term care; Care provided in a: rest home, home for the aged, halfway house, health resort, college infirmary or any similar facility for domiciliary or Custodial Care, or that provides twenty-four (24) hour non-medical residential care or day care (except as provided for Hospice care).
9. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein).
10. 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.
11. Injury resulting from participation in any hazardous activity, including: travel in or upon an ATV (all terrain or similar type two or three wheeled vehicle and/or off-road four wheeled motorized vehicles; motor vehicles not primarily designed and licensed for use on public streets or highways or parachuting, hang gliding, skydiving, parasailing, scuba diving, skin

- diving, glider flying, sailplaning, racing or speed contests, mountaineering (where ropes or guides are customarily used), rock wall climbing, rodeo or bungee jumping; (except as specifically provided in this Policy).
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 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, 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.
 14. Pregnancy that results under a Surrogate Parenting Agreement.
 15. Elective termination of pregnancy, except to preserve the life of the female upon whom the abortion is performed.
 16. Hospital Confinement or any other services or treatment that are received without charge or legal obligation to pay; Inpatient Room & Board charges in connection with a Hospital stay primarily for environmental change; Inpatient room & board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an Outpatient basis.
 17. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee; Services rendered by employees or Physicians or other persons or retained by the University or for the use of the Universities facilities.
 18. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
 19. Expenses that would be payable or medical treatment that is available, under any governmental or national health plan for which the Covered Person could be eligible.
 20. Services received before the Covered Person's Effective Date or during an Inpatient stay that began before the Insured's Effective Date; Services received after the Covered Person's Coverage ends, except as specifically provided under the Extension of Benefits provision.
 21. Services of a private duty Nurse.
 22. Under the Prescription Drug Benefit, any drug or medicine:
 - Obtainable Over the Counter (OTC), except as specifically provided under Preventive Care;
 - For the treatment of alopecia (hair loss) or hirsutism (hair removal);
 - For the purpose of weight control;
 - Anabolic steroids used for body building;
 - Growth hormones (unless Medically Necessary for treatment of Sickness);
 - 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 thirty (30) day supply;
 - Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
 - Purchased after Coverage under the Policy terminates;
 - Consumed or administered at the place where it is dispensed;
 - If the FDA determines that the drug is:
 - i. contraindicated for the treatment of the Condition for which the drug was prescribed; or
 - ii. Experimental for any reason.
 23. Vitamins, minerals, food supplements, herbs, herbal formulas, or home remedies; except as prescribed.
 24. Vocational recreation, art, dance, poetry, music, or other similar-type therapies, including regression therapy; personal enhancement or self-actualization therapy.
 25. Injuries sustained as a result of or any attempt at intentional self-inflicted Injury or any attempt at intentional self-inflicted Injury.
 26. 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.
 27. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
 28. War or any act of war, declared or undeclared; or while in the armed forces of any country.
 29. Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations.

30. 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.
31. Weight increase or reduction services, except as specifically provided in the Policy; general fitness, exercise programs, health club memberships and weight management programs; exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Physician's prescription.
32. Treatment received in the Covered Persons Home Country or outside of the United States of America, except when Medically Necessary for an Emergency Confinement in a Hospital or as provided.
33. Non-cystic acne.
34. Acupressure, aroma therapy, hypnosis, rolfing, Hyperhidrosis, Psychosurgery & biofeedback.
35. 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.
36. Elective Treatment, except as specified in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT

If the Eligible Person, within 365 days from the date of an Accident which occurs while Coverage is in force dies as the result of an Injury from such Accident, We will pay the Eligible Person's beneficiary the amount for loss of life as shown in the Schedule of Benefits. If the Eligible Person, within 365 days from the date of an Accident, which occurs while Coverage is in force, suffers dismemberment as the result of Injury from such Accident, We will pay the Eligible Person the amount set opposite such loss, as shown on the Schedule of Benefits. If more than one (1) such loss is sustained as the result of one (1) Accident, We will pay only one (1) amount, the largest to which the Eligible Person or his or her beneficiary would be entitled.

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

Life.....	\$10,000
Both hands or both feet or the entire sight of both eyes.....	\$10,000
One hand or one foot or the entire sight of one eye.....	\$5,000
More than one of the above Losses due to one Accident	\$10,000

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

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

MEDICAL EVACUATION BENEFIT

If the Insured cannot continue his academic program because he sustains an Accidental Injury or Emergency Sickness while Insured under the Policy and is more than a 100 mile radius from his current place of primary residence or outside of his Home Country, We will pay for the actual charge Incurred for an emergency medical evacuation of the Covered Person to or back to the Insured's home state, country, or country of regular domicile. No payment will be made under this provision unless the evacuation follows a Hospital Confinement of at least five (5) consecutive days. Before We make any payment, We require written certification by the Attending Physician that the evacuation is necessary. Any expense for medical evacuation requires Our prior approval and coordination. For international students, once evacuation is made outside the country, Coverage terminates. This Benefit does not include the transportation expense of anyone accompanying the Covered Person or visitation expenses.

REPATRIATION OF REMAINS BENEFIT

If the Covered Person dies while Insured under the Policy and is more than 100 miles from his permanent residence or outside of his Home Country, We will pay for the actual charge incurred for embalming, and/or cremation and returning the body to his place of permanent residence in his home state, country or country of regular domicile, up to the benefit amount shown in the Schedule of Benefits. Expenses for repatriation of remains require the Policyholder's and Our prior approval. If You are a United States citizen, Your Home Country is the United States. This Benefit does not include the transportation expense of anyone accompanying the body, visitation or lodging expenses or funeral expenses.

Eastern Washington University (International Students) 2015-2016 Schedule of Benefits		
Covered Charges for Essential Health Benefits (Ambulatory Patient Services)	In-Network Benefit	Out-of-Network Benefit
Policy Year Maximum Benefit	Unlimited	
Deductible per Covered Person per Policy Year (except as specified herein)	\$250	\$500
Out of Pocket Maximum – <ul style="list-style-type: none"> Includes Copayments; Deductibles & Prescription Drug Copayments; Excludes non-covered medical expenses & Elective services; Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year; Once the In-Network Out-of-Pocket Limit 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 Limit is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% Out-of-Network 	\$4,500 per Covered Person \$9,000 Family	\$9,000 per Covered Person \$18,000 Family
Insured Percent (except as specified herein)	80% of the Preferred Allowance (PA)	60% of the Reasonable and Customary Charges (R&C)
Preventive Care (See Definition for additional information. Also refer to Reproductive Services below.)		
Preventive Services	100% of PA + waiver of Deductible	60% of R&C
Outpatient Services - (other than Surgery, Maternity, Mental Health Treatment/Chemical Dependency)		
Office visits, including Evaluation and Management and diagnostic services 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. Does not apply when related to surgery or Physical Therapy. Also includes treatments & associated supplies and services; Second Opinion access; therapeutic injections and related supplies.	80% of PA	60% of R&C
Consulting Physician/Specialists (other than Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician); Does not apply when related to surgery or Physical Therapy.	80% of PA	60% of R&C
Diagnostic Imaging Includes x-ray services which are diagnostic or therapeutic.	80% of PA	60% of R&C
Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.	80% of PA	60% of R&C
Genetic Testing - Limited to five (5) tests per Cover Person per lifetime.	80% of PA	60% of R&C
Blood and Blood Products - Includes blood storage and blood bank services and supplies.	80% of PA	60% of R&C
CT Scan, CAT, MRI, and /or PET Scans	80% of PA	60% of R&C
Infusions (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	60% of R&C
Injections (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	60% of R&C
Radiation & Chemotherapy – includes education and supplies for self administered chemotherapy	80% of PA	60% of R&C
Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - includes administration and supplies. Coverage is provided for in home and outpatient dialysis services.	80% of PA	60% of R&C
Diagnostic procedures – including but not limited to Colonoscopies, Cardiovascular testing (including Pulmonary function studies) and Neurology/Neuromuscular procedures.	80% of PA	60% of R&C
Inpatient Service (other than Surgery, Maternity, Mental Health Treatment/Chemical Dependency)		
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, dialysis, miscellaneous items used in association with a surgical event, Pre-Admission Testing and Inpatient Rehabilitation.	80% of PA	60% of R&C
Room and Board expense ¹ , daily semi-private room rate and general nursing care provided by the Hospital. Note: Only one (1) Copayment amount, if any, for Room and Board, and Intensive Care Room applies to each admission for the same Condition.	80% of PA	60% of R&C
Intensive Care Room ¹ Note: Only one (1) Copayment amount, if any, for Room and Board, and Intensive Care Room applies to each admission for the same Condition.	80% of PA	60% of R&C
Physician visit, during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility. Includes Second Opinion.	80% of PA	60% of R&C

Consulting Physician, when requested and approved by the Attending Physician.	80% of PA	60% of R&C
Inpatient Rehabilitation Facility ¹ : – Including professional services offered within the facility.	80% of PA	60% of R&C
Skilled Nursing Facility and Sub-Acute Care Facility ¹ - Includes semi-private room and board, all professional services, general nursing services, meals and prescribed diets & medicines, supplies, Diagnostic Imaging, laboratory, and Rehabilitation.	80% of PA	60% of R&C
Surgical Services ¹ (Inpatient and Outpatient)		
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 one (1) or more incisions 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 50% of the Benefit otherwise payable for each subsequent procedure.		
Surgeon	80% of PA	60% of R&C
Assistant Surgeon - 25% of Surgeon's payment	80% of PA	60% of R&C
Anesthetist Services - 25% of Surgeon's payment	80% of PA	60% of R&C
Inpatient Surgical Miscellaneous - Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	80% of PA	60% of R&C
Outpatient Surgical Miscellaneous - Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.	80% of PA	60% of R&C
Other Surgical Services ¹		
General Anesthesia for Dental services	80% of PA	60% of R&C
Reconstructive Surgery	80% of PA	60% of R&C
Organ Transplant Surgery	80% of PA	60% of R&C
Organ Donor Services	80% of PA	60% of R&C
Gender Reassignment Surgery - Coverage is provided only with a diagnosis of gender dysphoria.	80% of PA	60% of R&C
Reproductive Services		
Voluntary Sterilization Surgery	80% of PA	60% of R&C
Note: Sterilization procedures for women are covered under Preventive Care.		
Infertility Services - Includes diagnosis of infertility and the treatment of an underlying condition causing infertility. Excludes infertility treatment.	80% of PA	60% of R&C
Contraceptives, including devices and related procedures, except as provided under the Prescription Drug Benefit.	100% of PA + waiver of Deductible	60% of R&C
Maternity Care – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided.		
Pre- and Post-Natal Care – Includes delivery and Inpatient Physician visits for mother and baby.	Paid as any other Sickness	
Hospital services ¹ - Includes room and board, general nursing care, meals and prescribed diets, pharmaceuticals administered while an Inpatient, anesthesia, dressings, other miscellaneous items, rooming in for maternity care, delivery, routine newborn care, including circumcision, or sick newborn care.	Paid as any other Sickness	
Diagnostic services performed and billed by a Physician's office, including ultrasounds and amniocentesis.	Paid as any other Sickness	
Mental Health Treatment/Chemical Dependency		
Inpatient services ¹ - including Alcoholism/Drug detoxification.	Paid the same as any other Sickness	
Outpatient Office Visits (office visit Copayments are not applied)	80% of PA	60% of R&C
Urgent Care and Emergency Services		
Urgent Care (including provider services; facility costs and supplies)	80% of PA	60% of R&C
Emergency services – visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition. Includes Physician's fees, Diagnostic Imaging, Laboratory, Injections, use of Emergency Room and supplies, emergency prescription drugs and facility charges. Copayment waived if admitted. Out-of-Network charges will never be more than \$50 over the In-network charges.	80% of PA after a \$100 Copayment per visit	80% of PA after a \$100 Copayment per visit
Emergency Medical Transportation services – includes treatment provided as part of the ambulance service	80% of PA	60% of R&C

Other Services		
Allergy testing – limited to one (1) test per Policy Year.	80% of PA	60% of R&C
Allergy Services (injections/treatment) – Includes treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments. Also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.	80% of PA	60% of R&C
Clinical Trials - Includes coverage for routine patient costs associated with a Covered Person's participation in a clinical trial, including prescription drugs that are not the subject of the trial, but are prescribed as part of the trial. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care of the Covered Person.	80% of PA	60% of R&C
Habilitative care – including Physical, Speech, Occupational and Aural therapies – only when prescribed by the Attending Physician. Includes services provided in a school based setting. Maximum of twenty-five (25) visits per Policy Year per therapy.	80% of PA	60% of R&C
Rehabilitative care – including Physical, Speech & Occupational therapies – only when prescribed by the Attending Physician. Maximum of twenty-five (25) visits per Policy Year per therapy.	80% of PA	60% of R&C
Pulmonary Therapy	80% of PA	60% of R&C
Cardiac Therapy	80% of PA	60% of R&C
Neuro-Developmental Therapy - Limited to thirty (12) hours of treatment per Policy Year unless treatment is for services with a DSM diagnosis.	80% of PA	60% of R&C
Chiropractic care	80% of PA after a \$15 Copayment per visit	60% of R&C after a \$15 Copayment per visit
Spinal manipulation services – up to ten (10) visits per Policy Year.	80% of PA	60% of R&C
Acupuncture – up to thirty (30) visits per Policy Year. Visit limits do not apply for chemical dependency treatment.	80% of PA	60% of R&C
Respiratory Therapy	80% of PA	60% of R&C
Dermatology (not including treatment of acne)	80% of PA	60% of R&C
Podiatry - only when prescribed by the Attending Physician.	80% of PA	60% of R&C
Home Health Care services	80% of PA	60% of R&C
Hospice- Includes fourteen (14) days of respite care for the Family Member acting as primary caregiver.	80% of PA	60% of R&C
Diabetic treatment and self management education - Includes supplies and services, including but not limited to, test strips, insulin and insulin syringes and glucagon emergency kits.	Paid as any other Sickness	
Prosthetic and Orthotic Devices - Includes replacement, repair, fitting and adjustment.	80% of PA	60% of R&C
Durable Medical Equipment (DME) – Includes cochlear implants. DME for Hospice and/or Home Health Care will be paid the same as Inpatient DME. Coverage for DME includes sales tax.	80% of PA	60% of R&C
Dental treatment due to Injury to a Sound Natural Tooth – Includes emergency treatment; oral surgery due to trauma or injury and preparation of the jaw for radiation treatment of neoplastic disease. Treatment must be received within ninety (90) days of Injury.	80% of PA	60% of R&C
Nutritional counseling – up to three (3) visits per Policy Year (except for treatment of diabetes – unlimited).	80% of PA	60% of R&C
Phenylketonuria - Includes diagnosis and formulas for treatment of PKU or similar inherited metabolic disorder.	80% of PA	60% of R&C
TMJ – Treatment for the dysfunction of the temporomandibular joints, including surgery of the jaw to correct or treat TMJ. Limited to one (1) surgery per Policy Year.	80% of PA	60% of R&C

Pediatric Dental and Vision Services for Covered Persons under the age of nineteen (19) – Refer to the Pediatric Vision Services and Pediatric Dental Services provisions in the Policy and Certificate for additional details, including applicable limitations and exclusions.		
<p>Pediatric Dental - preventive & diagnostic services, limited to 1 exam/prophylaxis every 6 month. Includes two limited visual oral assessments/screens per Covered Person under the age of nineteen (19)</p> <p>Also includes:</p> <ul style="list-style-type: none"> • Topical fluoride treatment – 3 per 12 months for age 6 and under or during orthodontic treatment; 2 per 12 months for age 7+; • X-rays-bitewing- 1 set per 12 months; • X-rays-full mouth complete or panoramic-1 per 36 months • Sealants, as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months; • Oral hygiene instruction – 2 per 12 months for ages 8 and under (if not billed on the same day as prophylaxis); • Space maintainers for missing primary molars only. Replacements covered on a case by case basis. 		100% of R&C
<p>Pediatric Dental – basic restorative services.</p> <p>Includes:</p> <ul style="list-style-type: none"> • Fillings (amalgam, resin-based composite) - 1 per tooth per 24 months • Prefabricated stainless steel crown – 1 per tooth per 36 months for primary anterior teeth (prior authorization required for ages 13+) and permanent posterior teeth; • Crowns* - metal/porcelain and porcelain on anterior teeth only; • Periodontics* - scaling and root planning and periodontal maintenance; limited to 1 every 24 months for ages 13+; • Endodontics - pulp cap; therapeutic pulpotomy; • Prosthodontics – denture repair, denture rebase/reline (1 per 36 months; 6 months after initial installation); • Emergency palliative treatment of pain; • Simple extractions; <p>*Requires pre-authorization</p>		70% of R&C
<p>Pediatric Dental – major services.</p> <p>Includes:</p> <ul style="list-style-type: none"> • Prosthodontics* - bridges* and dentures*: resin based partial denture limited to 1 per 36 months; complete upper and lower 1 per 60 months (one replacement denture per lifetime); • Endodontics - root canals on baby primary posterior teeth only*; root canals on permanent teeth* (excluding teeth 1, 16, 17 and 32); • Periodontics* – including gingivectomy or gingivoplasty; • Oral surgery, including frenulectomy/frenuloplasty for ages 6 and under; • General anesthesia and IV sedation* – in conjunction with complex oral surgery; • Analgesia or non-IV conscious sedation (not in conjunction with general anesthesia or IV sedation); <p>*Requires pre-authorization</p>		50% of R&C
<p>Pediatric Dental – Medically Necessary orthodontia services*, for Covered Persons under nineteen (19), as indicated in the Policy.</p> <p>Subject to 12 -month waiting period for services.</p> <p>*Requires pre-authorization</p>		50% of R&C
Frequency limitations may apply. Benefits are provided in accordance with state requirements.		
<p>Routine Vision - Includes:</p> <ul style="list-style-type: none"> • 1 exam/fitting per Policy Year, including dilation if professionally indicated; • Prescription eyeglasses (lenses and frames), or one pair of Medically Necessary contact lenses or a one year supply of disposable contact lenses in lieu of eyeglasses, limited to once per Policy Year; • Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes. 		100% up to \$150; 50% thereafter
Outpatient Prescription Drugs		
<p>Retail Prescription Drugs - per prescription or refill, subject to dispensing limits. The Pharmacy Benefits Manager (PBM) is: Cigna Pharmacy.</p> <p>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.</p>		
3 Tier Plan	Participating Pharmacy	Non-Participating Pharmacy
1. Generic Drugs	100% after a \$15 Copayment	50% after a \$15 Copayment
2. Preferred Brand Drugs	100% after a \$35 Copayment	50% after a \$35 Copayment
3. Non-Preferred Brand & Specialty Drugs	100% after a \$70 Copayment	50% after a \$70 Copayment
<p>Note: Please visit www.cigna.com to request a copy of the formulary.</p> <p>Only a thirty (30) day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy;</p> <ul style="list-style-type: none"> • One (1) Copayment per thirty-one (31) day supply; \$0 Copayment for Generic Contraceptives at a Participating Pharmacy only; 		

- Includes prescription contraceptives, prescription sterilization, and contraceptive devices (including insertion and extraction) 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;
- Includes preventive medications including, but not limited to, aspirin, fluoride, and iron;
- ADD and ADHD-related drugs are covered;
- The Deductible does **not** apply.

Elective Treatment

Medical Evacuation/Repatriation – \$25,000 per year maximum benefit per service. Includes a family travel benefit – up to \$5,000 per Policy Year. 100% of actual charges.

Out of country coverage – non-emergency medical treatment, if not covered by any other coverage. Maximum benefit \$20,000 per Policy Year paid at 50% of actual charges.

Sickness Dental - for services if a Doctor for removal of impacted wisdom teeth, No other benefits for impacted wisdom teeth will be paid. – 80% of R&C up to a maximum of \$125 per tooth, maximum of \$500 per Policy Year.

Explanation of Reference Number

¹ Must be Pre-Certified/Pre-Notified

CLAIM PROCEDURES

In the event of Injury or Sickness, students should:

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

**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: S213915

CLAIMS APPEAL PROCESS

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

**Claims Administrator:
CONSOLIDATED HEALTH PLANS**

2077 Roosevelt Avenue
Springfield, MA 01104
www.chpstudent.com
(413) 733-4540

Servicing Agent:

Wells Fargo
10940 White Rock Road, 2nd Floor
Rancho Cordova, CA 95670
(800) 853-5899
Studentinsurance.wellsfargo.com

This plan is underwritten by and offered by:
NATIONWIDE LIFE INSURANCE COMPANY

Columbus, OH

Policy Number: **302-004-4613**

For a copy of the privacy notice you may go to:

www.consolidatedhealthplan.com/about/hipaa

VALUE ADDED SERVICES

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.chpstudent.com

NURSE HOTLINE FOR STUDENTS

For quick, sound medical advice from specially trained Nurses

24 hours a day, 365 days per year

Call toll free at 800-557-0309

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

FrontierMEDEX ACCESS services is a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence. FrontierMEDEX is your key to travel security.

For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867.

If you have a medical, security, or travel problem, simply call FrontierMEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 1-800-527-0218 or if you are in a foreign country, call collect at: 1-410-453-6330.

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. FrontierMEDEX will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

