

BROCHURE OF COVERAGE

Blanket Accident & Sickness Plan
a Non-Renewable Term Policy

Designed for Students Attending

MANHATTAN CHRISTIAN COLLEGE

Manhattan, Kansas 66502

2013 • 2014

Policy Form No. 302-003-1511

Underwritten by:
Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Administered by:



www.sas-mn.com
333 N. Main St. Suite 300 • P.O. Box 196
Stillwater, MN 55082-0196

NOTICE:

Your student health insurance coverage, offered by Nationwide Life Insurance Company, may not meet the minimum standards required by the Health Care Reform Law for the restrictions on annual dollar limits for health insurance plans other than student health insurance coverage for the 2013/2014 policy year.

Minimum restrictions for policy year dollar limits for student health insurance coverage are \$500,000 for the 2013/2014 policy year. Your student health insurance coverage has a policy year limit of: \$500,000 for all conditions combined.

Be advised that you may be eligible for coverage under your parents' plan if you are under the age of 26. If you have any questions or concerns about this notice, contact Student Assurance Services, Inc. at 1-800-328-2739.

INTRODUCTION

The College is making available a plan of blanket accident and sickness insurance (hereinafter called "plan" or "Plan") underwritten by Nationwide Life Insurance Company and administered by Student Assurance Services, Inc. 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 on Student Assurance Services website www.sas-mn.com. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

The insurance plan provides continuous protection, 24 hours a day, anywhere in the world during the period of coverage for which the proper premium has been paid. Coverage is not automatically renewed. Students must re-enroll when coverage terminates to maintain continuous coverage.

SUMMARY OF PLAN BENEFITS

- The policy maximum benefit is \$500,000 for all covered injury and sickness.
- Benefits are subject to a policy deductible, in-network \$300 per person or out-of-network \$600 per person, for each covered injury or sickness. The deductible is reduced to \$150 when the student receives treatment from Lafene Health Center.
- Repatriation and medical evacuation benefits providing 24-hour assistance services are included.
- A 24-hour nurse line program providing phone-based health information is included.
- To maximize savings and reduce out-of-pocket expenses, select a First Health in-network provider. These providers have agreed to provide services at discounted rates.

For assistance and questions about insurance benefits, ID cards, claim status, or claim processing contact the Plan Administrator:

Student Assurance Services, Inc. (SAS)
Post Office Box 196
Stillwater, MN 55082-0196
www.sas-mn.com
Phone: (800) 328-2739

OTHER CONTACT INFORMATION:

Servicing Agent:
Student Assurance Services, Inc.
P.O. Box 3126
Lawrence, KS 66046
(800) 520-9909

Preferred Provider Directory or Questions
First Health Network
Customer Service:
Toll-Free: (888) 685-7774
Website: www.firstthealth.com

SAS Plan Number:
15-61-0027-200-685-3

STUDENT ELIGIBILITY

All undergraduate, graduate students and international students taking credit hours are eligible to enroll in the insurance plan.

All students are required to purchase this coverage, unless a completed waiver form with proof of other comparable insurance coverage is furnished to the MCC Business Office. The premium for this coverage will be charged to the student's tuition billing. Students may enroll dependents on a voluntary basis.

Students taking the following courses are not eligible to enroll in the insurance plan: distance learning courses; students solely taking off-campus internet, home study, correspondence, or television courses; courses taken for audit.

Students must be physically and actively attending classes to enroll in the insurance plan. Except for medical withdrawal due to a covered injury or sickness, any insured withdrawing from the College must submit documentation or certification of the medical withdrawal to the Plan Administrator at least 30 days prior to the medical leave of absence from the College, if the medical reasons for the absence are foreseeable, or 30 days after the start date of the medical leave of absence from the College. Any student voluntarily withdrawing from the College during the first 31 days after the effective date of coverage shall not be covered under the insurance plan and a full refund of premium will be made minus the cost of any claim benefits paid by us. Students who graduate or withdraw from College after 31 days, whether involuntarily or voluntarily, will remain covered under the Policy for the term purchased and no refund will be allowed.

The Plan Administrator reserves the right to determine if the student has met the eligibility requirements. If the Plan Administrator later determines the eligibility requirements have not been met, its only obligation is to refund the premium.

COVERAGE FOR DEPENDENTS

Students who enroll in the insurance plan may also enroll their eligible dependents by the enrollment period deadline dates shown on page 4. Enrollment forms and premium payments received after this date will only be accepted for dependents of new students and dependents who qualify for late enrollment. Dependents must enroll when the student first enrolls in the insurance plan and must enroll for the same coverage as the student.

TO ENROLL FOR COVERAGE

Complete the enrollment form and return it with your tuition check made payable to:

MANHATTAN CHRISTIAN COLLEGE
1415 ANDERSON AVE. • MANHATTAN, KS 66502

ID CARDS

An ID card will be mailed to the student's address on file approximately 2 weeks after the enrollment form and premium payment are received. Students do not need an ID card to be eligible to receive benefits under the Policy. For lost ID cards, request an ID card from the website www.sas-mn.com.

PERIODS OF COVERAGE AND ENROLLMENT PERIOD DEADLINE DATES			
TERM	DATE COVERAGE BEGINS	DATE COVERAGE ENDS	ENROLLMENT PERIOD DEADLINE DATE
FALL	08-01-2013	01-16-2014	09-16-2013
*SPRING/SUMMER	01-17-2014	07-31-2014	02-17-2014

*Spring/Summer term may be purchased by a new student not previously eligible to enroll for fall coverage or a student who purchased fall coverage and wishes to continue coverage.

Important: Enrollment forms and premium payments received after the enrollment period deadline date above are not accepted except for new students and late enrollment.

2013-2014 PREMIUM SCHEDULE		
	Fall	Spring/Summer
Student Only	\$ 518.00	\$ 600.00
Spouse	\$1,727.00	\$2,003.00
Each Child	\$ 987.00	\$1,145.00

Premium includes an agent service fee.

PREMIUM

Payment of Premium/Due Date: All premium, charges or fees must be paid to Plan Administrator prior to the start of the term for which coverage is selected, or to the College collecting premium payments as agreed upon by the College and Plan Administrator. In no event will coverage become effective prior to the date of enrollment and before required premium is received.

Returned or Dishonored Payment: If a check or credit card payment for the premium is dishonored for insufficient funds, a reasonable service charge may be charged to the insured which will not exceed the maximum specified under state law. A dishonored check or credit card payment shall be considered a failure to pay premium and coverage shall not take effect.

Premium Refund Policy: A prorated refund, less any claims paid, will be issued only for the following situations below. Any refund provided may be subject to a \$25 administration fee.

- Students who voluntarily withdraw from the College within the first 31 days following their effective date of coverage; or
- Students who have entered into full-time active duty military service for any country; or
- Students who are non-immigrant foreign nationals who have permanently left the North American Continent for their home country.

All premium refund requests must be made in writing and include any proof (such as airline ticket) and date of occurrence. Refund requests should be sent to:

Student Assurance Services, Inc.
P.O. Box 196 • Stillwater, MN 55082-0196

LATE ENROLLMENT

Students and dependents may enroll after the enrollment period deadline date only if there is a qualifying event. Qualifying events include involuntary loss of coverage under another insurance plan, marriage, birth of child, adoption of a child, or a step and foster child acquired after the insured's effective date. The insured must notify the Plan Administrator immediately when eligible for late enrollment. Coverage is effective upon enrollment and receipt of premium.

Involuntary Loss of Coverage: If the insured chose not to enroll in the insurance plan when first eligible as a result of coverage under another insurance plan, the insured may enroll if the Plan Administrator is notified in writing and the enrollment and premium are received no later than 31 days after the involuntary loss of coverage under the other insurance plan. This does not apply if the other insurance plan was voluntarily terminated.

Newborn Children: An insured's newborn child is automatically covered from the moment of birth until the child is 31 days old. Coverage for the child will be for sickness and injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, the insured must notify the Plan Administrator in writing within 31 days of the birth date and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such 31 day period.

Step-Child: Coverage for a step-child is effective on the date the insured marries the child's parent. However, the insured must notify the Plan Administrator in writing within 31 days of the marriage and pay the required additional premium, if any, in order to have coverage for the child continue beyond such 31 day period.

Foster Child: Coverage for a foster child is effective upon the date of placement with the insured. Coverage will continue unless the placement is disrupted and the child is removed from placement. However, the insured must notify the Plan Administrator in writing within 31 days of such placement and pay the required additional premium, if any, in order to have coverage for the foster child continue beyond the 31 day period.

Adopted Child: Coverage for an adopted child is effective upon the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage for such child will be for sickness and injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, the insured must notify the Plan Administrator in writing within 31 days of the adoption and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond the 31 day period.

Dependent Spouse: A dependent spouse is eligible for coverage on the date of marriage to the insured. However, the insured must notify the Plan Administrator in writing no later than 31 days from the date of marriage and pay the required additional premium.

Domestic/Civil Union Partner: A Domestic/civil union partner is eligible for coverage on the date the domestic/civil union partnership begins. Enrollment and premium must be received no later than 31 days from the date the domestic/civil union partnership begins. Refer to the Definition section in this brochure for the eligibility criteria for a domestic/civil union partner.

EFFECTIVE AND TERMINATION DATES OF COVERAGE

Coverage becomes effective on the later of the following dates:

- The Master Policy effective date August 1, 2013, at 12:01 a.m.,
- The first day of the term for which the proper premium is paid;
- 12:01 a.m. following the date the proper premium is received by the College.

Dependent coverage under the Policy becomes effective on the same date as the insured student for which the proper dependent premium payment is received. Coverage will not be effective prior to that of the insured student.

Coverage will terminate on the earliest of the following dates:

- the Master Policy termination date July 31, 2014, at 11:59 p.m.;
- the last day of the term of coverage for which the proper premium is paid;
- the date a foreign national permanently departs for their home country;
- the date the insured enters into full time active military service;
- the date the premium for insurance coverage is due and unpaid.

Dependent coverage will not extend beyond the student's termination date of coverage.

Coverage will continue for a handicapped dependent child who is not capable of self-support due to a mental retardation or physical handicap if:

1. The dependent child became incapacitated prior to the age at which coverage would otherwise have terminated;
2. The dependent child is primarily dependent on the student for support and maintenance;
3. Proof of such incapacity and dependence is given to the Plan Administrator by the attending physician within 31 days of the date the dependent child reaches the limiting age. Proof must also be given annually thereafter. Failure to provide such proof within 31 days of the request will result in the termination of the dependent child's coverage under the Policy.

Coverage will continue as long as the dependent child continues to satisfy the requirements above, unless coverage is otherwise terminated in accordance with the terms of the Policy.

IMPORTANT: Coverage is not automatically renewed. Students are responsible for keeping the Policy in force.

Extension of Benefits

The coverage provided under the Policy ceases on the insured's termination date, except for the following situation:

- The insured is hospital confined on the termination date from a covered injury or sickness for which benefits were paid before the termination date. The covered expenses for the injury or sickness will continue to be paid for a period of 90 days or until date of discharge, whichever is earlier.

Note: The total payments made for the covered expenses for the medical condition both before and after the termination date will never exceed the Policy maximum benefit. After the extension of benefits provision has been exhausted, all benefits cease to exist and under no circumstances will further benefits be paid.

SCHEDULE OF BENEFITS

Policy Maximum Benefit – per policy year	\$500,000	
	In-Network	Out-of-Network
Policy Deductible – per person, for each covered injury or sickness	\$300	\$600
<small>(a separate deductible may apply to covered services listed below)</small>		
Benefits are payable at the following insurer percentage of the In-Network Preferred Allowance or Out-of-Network Reasonable & Customary Charge - for each covered injury or sickness:		
- For the first \$2,000 in paid benefits	80%	60%
- For the next \$73,000 in paid benefits	60%	50%
- For the next \$425,000 in paid benefits	100%	90%
Student Health Benefits	Refer to page 8	Refer to page 8

COVERED SERVICES AND BENEFIT LIMITS	Up to \$2,000 In-Network/ Out-of-Network	Up to \$73,000 In-Network/ Out-of-Network	Up to \$425,000 In-Network/ Out-of-Network
<u>INPATIENT</u>			
HOSPITAL ROOM AND BOARD benefit is payable for semi-private room rate	80/60%	60/50%	100/90%
HOSPITAL INTENSIVE CARE benefit is payable for semi-private room rate	80/60%	60/50%	100/90%
HOSPITAL MISCELLANEOUS includes but is not limited to: general nursing services, 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, and other miscellaneous items used in association with the confinement; benefit is payable after \$500 copay per confinement	80/60%	60/50%	100/90%
SKILLED NURSING FACILITY	80/60%	60/50%	100/90%
ASSISTANT SURGEON	25% Surgeon's Fee	25% Surgeon's Fee	25% Surgeon's Fee
ANESTHESIA	25% Surgeon's Fee	25% Surgeon's Fee	25% Surgeon's Fee
PHYSIOTHERAPY SERVICES includes physical therapy and chiropractic care; 1 visit per day; benefit is payable up to maximum 30 visits per policy year	80/60%	60/50%	100/90%
CHEMOTHERAPY AND RADIATION THERAPY	80/60%	60/50%	100/90%
PHYSICIAN'S NON-SURGICAL VISITS 1 visit per day; not paid same day as surgery; includes benefit for consultant physician	80/60%	60/50%	100/90%
PRE-ADMISSION TESTING includes tests done in conjunction with scheduled surgery; within 3 working days of admission	80/60%	60/50%	100/90%
<u>OUTPATIENT</u>			
HOSPITAL EMERGENCY ROOM includes urgent care and all related expenses; benefit is payable after \$200 copay per visit; copay is waived if admitted	80%	60%	100%
HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS includes facility fee, diagnostic and x-ray services, laboratory services, pharmaceuticals administered, anesthesia, therapeutic services, supplies, and other miscellaneous items used in association with the covered treatment; benefit is payable after a \$500 copay per admission	80/60%	60/50%	100/90%
ASSISTANT SURGEON	25% Surgeon's Fee	25% Surgeon's Fee	25% Surgeon's Fee
ANESTHESIA	25% Surgeon's Fee	25% Surgeon's Fee	25% Surgeon's Fee
PHYSICIAN'S NON-SURGICAL VISITS includes benefit for consultant physician; 1 visit per day; not paid same day as surgery; benefit is payable after \$40 copay per visit; up to maximum 30 visits per condition	80/60%	60/50%	100/90%
PHYSIOTHERAPY SERVICES includes physical therapy and chiropractic care; 1 visit per day; benefit is payable up to maximum 30 visits per policy year	80/60%	60/50%	100/90%
DIAGNOSTIC, XRAY & LAB SERVICES	80/60%	60/50%	100/90%
MRI, CT SCAN, AND PET SCAN benefit is payable after a \$500 copay per procedure	80/60%	60/50%	100/90%
CHEMOTHERAPY AND RADIATION THERAPY	80/60%	60/50%	100/90%
INFUSION AND/OR INJECTIONS	80/60%	60/50%	100/90%
PRESCRIPTION DRUGS 30-day supply per prescription; see page 21; \$25 copay per generic drug or \$50 copay per brand drug	80/60%	60/50%	100/90%
HOME HEALTH CARE	80/60%	60/50%	100/90%

COVERED SERVICES AND BENEFIT LIMITS - Continued	Up to \$2,000 In-Network/ Out-of-Network	Up to \$73,000 In-Network/ Out-of-Network	Up to \$425,000 In-Network/ Out-of-Network
<u>OTHER INPATIENT OR OUTPATIENT</u>			
EMERGENCY MEDICAL TRANSPORTATION includes all related expenses	80%	60%	100%
SURGERY when performed inpatient, outpatient or in physician's office; multiple surgical procedures performed through the same incision shall be reimbursed for an amount not less than that for the most expensive procedure being performed. Multiple surgical procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the covered percentage of the covered charge of the most expensive surgical procedure then being performed, and with regard to the less expensive surgical procedure in an amount equal to 50% of the covered percentage of the covered charge for these procedures	80/60%	60/50%	100/90%
DURABLE MEDICAL EQUIPMENT AND ORTHOPEDIC APPLIANCE when prescribed by a physician; benefit is payable after \$50 copay per prescription	80/60%	60/50%	100/90%
MATERNITY includes 48 hours of inpatient care following a normal delivery and 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 benefits are payable for home health care visits	Same as any Sickness	Same as any Sickness	Same as any Sickness
MENTAL HEALTH Inpatient – benefit is payable the same as any Sickness, up to maximum 30 days per policy year Outpatient – benefit is payable the same as any Sickness, up to maximum 30 visits per policy year	As Described	As Described	As Described
ALCOHOL AND DRUG ABUSE Inpatient – benefit is payable the same as any Sickness, up to maximum 7 days per policy year Outpatient – benefit is payable the same as any Sickness, up to maximum 30 visits per policy year	As Described	As Described	As Described
PREVENTIVE CARE includes routine newborn, well child care, and well adult services, immunizations; deductible or copay does not apply; see pages 19-20; out-of-Network preventive care is not covered	100%/NC	100%/NC	100%/NC
<u>ELECTIVE TREATMENT</u>			
DENTAL TREATMENT coverage is limited to injuries to sound natural teeth; does not include biting or chewing injuries; benefit is payable up to maximum \$500 per dental injury	80/60%	60/50%	100/90%
PRIVATE DUTY NURSE when medically necessary during inpatient confinement and requested by the attending physician	80/60%	60/50%	100/90%

OTHER SCHEDULED BENEFITS

*STUDENT HEALTH SERVICE

When non-emergency care is needed, students are strongly encouraged to consider using the Student Health Service first. If the Student Health Service does not provide the care needed, they can provide the student with information to make informed health care decisions. The policy deductible will be reduced to \$150 when students are treated by the Lafene Health Center.

HOME COUNTRY COVERAGE

Benefits for medical treatment provided in the student's home country, outside the United States of America and not covered by any other medical coverage, is payable the same as any sickness or injury, up to policy year maximum of \$20,000.

BENEFITS MANDATED BY THE STATE OF KANSAS

The Policy pays benefits in accordance with any applicable Kansas law. State-mandated benefits are listed below. Description of the mandates can be found in the Master Policy. Benefits may be subject to deductibles, coinsurance, limitations, or exclusions.

- Anesthesia and Hospital Benefit for Dental Procedures
- Direct Access to Obstetricians and Gynecologists
- Off-label Prescription Drug Coverage for Cancer
- Routine Costs: Cancer Clinical Trials

ADDITIONAL PROGRAMS

***GLOBAL EMERGENCY SERVICES** (Travel Assistance) see details on page 14-15

***ASK MAYO CLINIC** (Nurse Line) see details on page 15

***Note: These additional programs are not underwritten by Nationwide Life Insurance Company, but provided by independent vendors and are included if students participate in the insurance plan.**

EXPLANATION OF BENEFITS

BENEFIT PAYMENTS

Benefits are payable only for covered expenses incurred during the policy period. No benefits are payable for covered expenses incurred prior to or after the insured's effective or termination dates respectively. Covered expenses are payable at the in-network insurer percentage for the preferred allowance or the out-of-network insurer percentage for the provider reasonable and customary charges. Benefits will be payable for each covered injury or sickness up to the policy year maximum. In addition to the policy maximum benefit, the Policy may contain benefit-level maximums for a covered expense, as outlined in the Schedule of Benefits. The insured is responsible for the deductible, copay, coinsurance and the balance of expenses not paid by the Policy.

PRECERTIFICATION AND REFERRALS

This insurance plan does not require pre-certification or referrals for emergency services, to obtain access to providers specializing in obstetrics or gynecology, or any covered service prior to the date the service is performed. Covered services will be evaluated for benefits when the claim is submitted to the Plan Administrator for payment. A verbal explanation of benefits does not guarantee payment of claims.

PAYMENT DEFINITIONS

Covered services payable under the Policy, are subject to the following payment provisions as described below.

Coinsurance is the insured's share of the costs, calculated as a percentage, after the Policy pays the insurer percentage.

Copay is the fixed dollar amount the insured must pay for specified covered expenses, each time the covered service is received. The prescription drug copay is not paid at the pharmacy, but rather is subtracted from benefits when a claim is submitted by the insured for payment.

Deductible is the amount subtracted from covered expenses before benefits are considered. Each insured person or family must satisfy the deductible. A deductible may be required for each injury or sickness, once per policy period, or each time the covered service is received.

Insurer Percentage is the percentage of covered expenses the Policy pays, after the deductible or copay is satisfied. Refer to the Schedule of Benefits for the amount.

Policy Maximum Benefit: The maximum amount of benefits the Policy will pay for all covered conditions (injury and sickness) each policy year for each covered person. This amount is shown in the Schedule of Benefits.

MEDICAL NECESSITY and MEDICAL APPROPRIATENESS DETERMINATION

The Company reserves 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 the Company for covered services that are not medically necessary and/or medically appropriate. In the event of such a denial, the insured will be liable for the entire amount billed by that provider. The insured has the right to appeal any adverse decision as outlined in the Appeals and Complaint section of this brochure.

Covered Services are medically necessary if they are:

- Required to meet the health care needs of the insured; 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 insured 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.

EXPLANATION OF BENEFITS cont.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- is experimental/investigational or for research purposes;
- is provided solely for educational purposes or the convenience of the patient, the patient's family, physician, hospital or any other physician; exceeds in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- could have been omitted without adversely affecting the patient's condition or the quality of medical care;
- involves treatment with or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA). If the prescribed drug is recognized as safe and effective for the treatment of a sickness or injury by one or more of the Standard Medical Reference Compendia or in the medical literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific sickness or injury, coverage will be provided, subject to the exclusions and limitations of the Policy;
- can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

If the insured has other insurance and pre-certification is required, this coverage will consider the services authorized by the primary carrier as medically necessary and process the insured's claim accordingly unless otherwise excluded under the Policy. If the insured has any questions or concerns about whether a particular service, supply, or treatment is medically necessary or medically appropriate, contact the Plan Administrator.

PRE-EXISTING CONDITION

Pre-existing condition means any condition which originates, is diagnosed, treated or recommended for treatment within the 12 consecutive months prior to the insured's effective date of coverage under the Policy. Pre-existing conditions are not covered for the first 12 months following the insured's effective date of coverage under the Policy.

This limitation will not apply:

- If, during the period immediately preceding the insured's effective date of coverage under the Policy, the insured was covered under prior creditable coverage for 12 consecutive months. Prior creditable coverage of less than 12 months will be credited toward satisfying the pre-existing condition limitation. This waiver of pre-existing conditions will apply only if the insured becomes eligible and applies for coverage within sixty-three (63) days of termination of his or her prior coverage.
- Genetic disorders.
- to any insured under the age of nineteen (19).

Creditable Coverage: The insured must provide us proof of prior creditable coverage.

- Any individual or group policy, contract or program, that is written or administered by a disability insurance Company, health care service plan, fraternal benefits society, self-Insured employer plan, or any other entity, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage **but does not include:** accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
- The federal Medicare programs pursuant to Title XVIII of the Social Security Act.
- The Medicaid program pursuant to Title XIX of the Social Security Act.
- Any other publicly sponsored program, provided in this state or elsewhere, of medical, Hospital and surgical care.
- 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed services (CHAMPUS)).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal -Employees Health Benefits Program (FEHBP)).
- A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
- A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).
- Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).
- Title XXI of the federal Social Security Act, State Children's Health Insurance Program.

GENERAL EXCLUSIONS AND LIMITATIONS

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 in Schedule of Benefits.
2. Hearing Screenings (except as provided in the Schedule of Benefits) 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 provided in the Schedule of Benefits): 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.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that the Company determines 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 Schedule of Benefits. 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. Sexual/gender reassignment surgery, including, but not limited to, hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, phalloplasty, orchiectomy, penectomy, vaginoplasty, clitoroplasty, labiaplasty or any treatment of gender identity disorders, including hormone replacement therapy. This exclusion does not include related mental health counseling.
7. 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.
8. 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 the insured has a terminal condition that, according to the physician's current diagnosis, has a high probability of causing death within 1 year from the date of the request for medical review.
9. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, except as provided in the Schedule of Benefits.
10. Temporomandibular Joint Dysfunction (TMJ).
11. Injury sustained while (a) participating in any interscholastic, intercollegiate, professional, semi-professional, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition.
12. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such benefits 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.

GENERAL EXCLUSIONS AND LIMITATIONS cont.

13. 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.
14. Reproductive/Infertility services, unless caused by injury or sickness, including but not limited to: family planning treatment of infertility (male or female) including diagnosis, diagnostic tests, 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. Examples of fertilization procedures are ovulation induction procedures, invitro fertilization, artificial insemination, embryo transfer or similar procedures that augment or enhance insured's reproductive ability.
15. Elective termination of pregnancy.
16. Services provided normally without charge by the health service of the policyholder or services covered or provided by a student health fee.
17. Treatments which do not meet the national standards for mental health professional practice; telemedicine, methadone maintenance or treatment.
18. For injury caused by, contributed to or resulting from the covered person's use of alcohol, illegal drug or use of legal medicines that are not taken in the dosage or for the purpose as prescribed by the covered person's physician.
19. Injuries sustained as a result of suicide or any attempt at suicide, including drug overdose or intentional self-inflicted Injury or any attempt at intentional self-inflicted injury.
20. 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.
21. Injury or sickness related to your job to the extent you are covered or are required to be covered by Worker's Compensation law. If you enter into a settlement giving up your right to recover future medical benefits under a Worker's Compensation law, the Policy will not pay those medical benefits that would have been payable in the absence of the settlement.
22. War or any act of war, declared or undeclared; or while in the armed forces of any country.
23. 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.
24. Treatment received in the covered person's home country outside of the United States of America, except as provided in the Schedule of Benefits.
25. Acupuncture.
26. 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.
27. Elective surgery or treatment.

ADDITIONAL PROGRAMS
(*These programs are not underwritten by Nationwide Life Insurance Company)

PREFERRED PROVIDER NETWORK

Persons insured under the plan may choose to be treated within, or out of, the First Health preferred provider network. The First Health preferred provider network consists of hospitals, doctors, and other health care providers, that are organized into a network for the purpose of delivering quality health care at a negotiated fee. If medical treatment is obtained from a First Health preferred provider, a higher reimbursement will be received toward the insured's covered medical expenses.

When an insured uses the services of a First Health preferred provider, the covered expenses are payable at the in-network percentage for the preferred allowance. When treatment is received by a non-preferred provider, covered expenses are payable at the percentage for the reasonable and customary charges incurred. The percentage for in-network and out-of-network can be found on the Schedule of Benefits on page 7-8.

Exception: Benefits will be paid at the in-network percentage for services provided by a non-preferred provider when admission or treatment is necessary in the event of a medical emergency.

The insured is not responsible for the difference between the First Health preferred provider's usual billed charges and the preferred allowance. The insured is responsible for the coinsurance; any differences due to deductibles, copays, benefit limitations, and exclusions.

In order to use the services of a First Health preferred provider, the insured must present the student accident and sickness insurance ID card.

A complete listing of First Health preferred providers is available on the website: www.firsthealth.com or by calling toll free (888) 685-7774. The participation of individual providers is subject to change without notice. It is the insured's responsibility to confirm a provider's participation in the First Health network when calling for an appointment or at time of visit.

***GLOBAL EMERGENCY SERVICES PROGRAM
(TRAVEL ASSISTANCE)**

Students who enroll and maintain medical coverage in this insurance plan are eligible for the global emergency services program administered by Scholastic Emergency Services (SES), an Assist America partner. This program provides 24-hour assistance services whenever the student is traveling more than 100 miles away from home, school, or abroad. International students studying in the United States are eligible for services both on and away from campus or while traveling in a country that is not their country of origin.

All assistance services must be arranged and provided by SES; no claims will be accepted for assistance services arranged or provided by anyone other than SES.

Note: This program does not replace medical insurance. All claims for medical expenses should be submitted to the Plan Administrator for consideration. The SES program meets or exceeds the requirements of USIA for international students and scholars. The following services are provided:

1. Medical Consultation, Evaluation & Referral - Calls to the Operations Center are evaluated by medical personnel and referred to the appropriate provider.
2. Foreign Hospital Admission Assistance - SES will guarantee hospital admission outside the United States by validating a student's health coverage or by advancing funds to the hospital. (Any emergency hospital admittance deposit must be repaid within 45 days.)
3. Emergency Medical Evacuation - If adequate medical facilities are not available locally, SES will use whatever mode of transportation, equipment and personnel necessary to evacuate the student or covered family member to the nearest facility capable of providing a high standard of care.
4. Medical Monitoring - SES medical personnel will maintain regular communication with the attending physician and/or hospital and relay information to student's family.
5. Medical Repatriation - If a student still requires medical assistance upon being discharged from a hospital, SES will repatriate him/her to a rehabilitation facility or home, and if necessary will provide a medical or non-medical escort.
6. Prescription Assistance - If a member needs a replacement prescription while traveling, SES will help in filling that prescription.

7. Compassionate Visit - When traveling alone and hospitalized for more than 7 days, economy, round trip, common carrier transportation to the place of hospitalization will be provided for a designated family member or friend.
8. Care of Minor Children - SES will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.
9. Return of Mortal Remains - SES will assist with the logistics of returning a member's remains home in the event of his or her death. This service includes locating the funeral home, arranging the preparation of the remains for transport, procuring required legal documentation, providing the necessary shipping container as well as paying for transport.
10. Legal Referrals - Referrals for interpreters or legal personnel are available.
11. Emergency Trauma Counseling - SES will provide initial telephone-based counseling and referrals to qualified counselors as needed or requested.
12. Lost Luggage or Document Assistance - SES will help members locate lost luggage, documents or personal belongings.
13. Pre-trip Information - SES offers members web-based country profiles that include visa requirements, vaccinations recommendations as well as security advisories for any travel destination.

For assistance call SES Operations Center toll free
inside the U.S. (877) 488-9833 or
outside the U.S. (609) 452-8570 or
email medservices@assistamerica.com.

***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.

DEFINITIONS

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

Alcoholism: Physical dependence on alcohol to the extent that stopping alcohol use will bring on withdrawal symptoms. Treatment, including rehabilitation and detoxification, must be provided by or under the clinical supervision of a physician or licensed psychologist. The services must be provided in one of the following:

- The physician's or psychologist's office;
- A hospital;
- A community mental health center or alcoholism treatment facility approved by the Joint Commission on Accreditation of Hospitals or certified by the State Department of Health.

Ambulatory Surgical Center: A facility which meets licensing and other legal requirements and which: 1) is equipped and operated to provide medical care and treatment by a physician; 2) does not provide services or accommodations for overnight stays; 3) has a medical staff that is supervised full time by a physician; 4) has full-time services of a licensed registered nurse (R.N.) at all times when patients are in the facility; 5) has at least one operating room and one recovery room and is equipped to support any surgery performed; 6) has x-ray and laboratory diagnostic facilities; 7) maintains a medical record for each patient; 8) and has a written agreement with at least one hospital for the immediate transfer of patients who develop complications or need confinement.

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.

Company: Nationwide Life Insurance Company.

Confinement/Confined: An uninterrupted stay following admission to a health care facility. The re-admission to a health care facility for the same or related condition, within a 72 hour period, will be considered a continuation of the confinement. Confined/confinement does not include observation, which is a review or assessment of 18 hours or less, of a person's condition that does not result in admission to a hospital or health care facility.

Covered Charge or Covered Expense: Means those charges for any treatment, services or supplies: (a) for network providers not in excess of the preferred allowance; (b) for non-network providers not in excess of the charges of the reasonable and customary expense therefore; and (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while the 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.

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

Dependent: A person who is the insured's:

- Legally married spouse, who is not legally separated from the insured and resides with the insured.
- Domestic/civil union partner who resides with the insured.
- Child who is under the age of 26.

The term child refers to the insured's: 1) natural child; 2) stepchild (a stepchild is a dependent on the date the Insured marries the child's parent); 3) 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; 4) foster child (a foster child is a dependent from the moment of placement with the insured as certified by the agency making the placement).

DEFINITIONS cont.

Domestic/Civil Union Partner: Two individuals who, together, each meet all of the following criteria set forth below:

1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic/civil union partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the domestic/civil union partner relationship voluntarily, willingly, and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes joint responsibility for each other's basic living expenses.
8. Have been living together as a couple for at least 6 months prior to obtaining the coverage provided under the Policy.
9. Intend to continue the domestic/civil union partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner.

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

Drug Abuse: Means any chemical component that one inhales, ingests, injects, or applies to one's body for purposes of non-therapeutic use. Drug abuse does not include alcoholism or alcohol abuse.

Durable Medical Equipment: A device which: 1) is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of sickness or injury and is able to withstand repeated use; 2) is used exclusively by the patient; 3) is routinely used in a hospital but can be used effectively in a non-medical facility; 4) can be expected to make a meaningful contribution to treating the patient's sickness or injury; and 5) is prescribed by a physician and the device is medically necessary for rehabilitation.

Durable medical equipment and medical supplies include, but are not limited to, the following:

- a. Mechanical equipment and monitors necessary for the treatment of chronic or acute respiratory failure, (environmental items are excluded);
- b. Manual hospital-type beds and mattresses;
- c. Canes, crutches, walkers or standard wheelchairs;
- d. Oxygen and equipment for its administration;
- e. Commode items, i.e. - bedside handrails, shower bench;
- f. Electronic larynx and voice prosthesis buttons;
- g. Equipment and supplies for the management and treatment of diabetes (except medications);
- h. Ostomy/ileostomy supplies;
- i. Special pressure pads;
- j. Medical elastic stockings (limited to 2 per year);
- k. Pumps and supplies to deliver an external product.

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

Effective Date: The date coverage becomes effective at 12:01 a.m. on this date. Coverage for dependents will never be effective prior to the insured's coverage.

Elective Treatment: Those services that do not fall under the definition of essential health benefits. Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the covered person's effective date of coverage. Elective benefits are shown on the Schedule of Benefits, as applicable.

Emergency: An illness, sickness or injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid severe harm. Emergency does not include the recurring symptoms of a chronic condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

DEFINITIONS cont.

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

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of covered Services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; 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).

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

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

Health Care Facility: A student health center, hospital, skilled nursing, sub-acute, or other duly licensed, certified and approved health care institution which provides care and treatment for sick or injured persons.

Home Health Care: Services and supplies that are medically necessary for the care and treatment of a covered illness or accidental injury and are furnished to a covered person at the covered person's residence. Home health care consists of, but shall not be limited to, the following: 1) Physician-directed Home Health Care follow-up visits provided to a mother or newborn child within 72 hours after the mother's or newborn child's early discharge from an inpatient stay. The Provider conducting the visit must have knowledge and experience in maternity and newborn care; and 2) Care provided in a covered person's home by a licensed, accredited home health care agency. This care must be under the direction of a physician and in conjunction with the need for skilled nursing care and includes, but is not limited to:

- skilled nursing (L.P.N., R.N.) part-time or intermittent care;
- medical social services;
- infusion services;
- part-time or intermittent certified nurse assistant services or home health aide services, which provide support in the home under the supervision of an R.N. or a physical, speech or occupational therapist. A visit of 4 hours or less by a certified nurse assistant or home health aide will count as 1 home health care visit. Each visit by any other home health agency representative will count as 1 home health care visit;
- physical therapy;
- occupational therapy;
- speech therapy.

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

Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include an institution, or part thereof, which is other than incidentally a nursing home, a convalescent hospital, or a place for rest or the aged.

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

Injection Services: Services provided in an office or outpatient facility, including the professional fee and related supplies. Injection services does not include self-administered injectable drugs.

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

Insured: The covered person who is enrolled, and meets the eligibility requirements of the Policyholder's school or dependents of the covered person.

Mental Condition(s): Nervous, emotional, and mental disease, illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a mental condition on the date of medical care or treatment is rendered to a covered person.

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 Year: The period of 12 months following the Policy's effective date.

Premium: The amount required to maintain coverage for each eligible person and dependent in accordance with the terms of the Policy.

Prescription Drugs: Drugs which may only be dispensed by written prescription under federal law and is: 1) approved for general use by the U.S. Food and Drug Administration (FDA); 2) prescribed by a licensed physician for the treatment of a life-threatening condition, or prescribed by a licensed physician for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the formulary, if any; and 3) the drug has been recognized for treatment of that condition by one of the standard medical reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies, even if the prescribed drug has not been approved by the FDA for the treatment of that specific condition.

The drugs must be dispensed by a licensed pharmacy provider for out of hospital use. Prescription drug coverage shall also include medically necessary supplies associated with the administration of the drug.

Preventive Services:

The preventive services provided by a network provider for periodic health evaluations, immunizations, and laboratory services in connection with periodic health evaluations as specified in the Schedule of Benefits. Benefits are considered based on the following criteria:

1. 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;
2. 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 insured involved;
3. For 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
4. For 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.

Cost sharing may apply to services provided during the same visit as the preventive services. For example if a covered preventive service is provided during an office visit and the preventive service is not the primary purpose for the visit, the cost sharing would apply to the office visit. Cost sharing may also apply for treatment that is not a covered preventive service, even if treatment results from a covered preventive service, or for any item or service that has ceased to be a covered preventive service. Reasonable medical management will be used to determine frequency, method, treatment, or setting for a preventive service.

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 preferred or 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.

Reconstructive Surgery: Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, disease, or accidental injury occurring while insured under the Policy to either: 1) improve function; or 2) create a normal appearance.

Sickness: Illness, disease or condition, including pregnancy and complications of pregnancy that impairs a covered person's normal functioning of mind or body and which is not the direct result of an injury or accident. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same sickness.

Skilled Nursing Facility: A place (including a separate part of a hospital) which: regularly provides room and board for person(s) recovering from illness or accidental injury; provides continuous 24 hour nursing care by or under the supervision of a registered nurse; is under the supervision of a duly licensed doctor; maintains a daily clinical record for each patient; is not, other than incidentally, a place for rest, the aged, place of treatment for alcoholism or drug and/or substance abuse or addiction; and is operated pursuant to law.

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

Sub-Acute Facility: A free-standing facility or part of a hospital that is certified by Medicare to accept patients in need of rehabilitative and skilled care nursing.

Termination Date: The date a covered person's coverage under this policy ends. Coverage ends at 11:59 p.m. on this date.

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

COORDINATION OF BENEFITS

The coordination of benefits (COB) provision applies to the Policy when the insured has medical insurance coverage under more than one plan. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the charges incurred

RESCISSION

The Plan Administrator may rescind your coverage if the insured or insured's dependent commits fraud or makes an intentional misrepresentation of material fact. A notice will be provided at least thirty (30) calendar days before the coverage is rescinded. The insured may appeal any rescission.

CLAIM PROCEDURE

Usually the health care provider will file all necessary bills on the insured's behalf. However, some providers may require payment at the time the service is provided or may send the bill directly to the insured. In these instances, the insured should file a claim and send all itemized medical or hospital bills to the address below.

PRESCRIPTION DRUG CLAIM PROCEDURE

To obtain reimbursement for a prescription drug, the insured will need to pay for the prescription drug at the pharmacy and submit a copy of the drug label with a claim form to the address below.

Bills must be submitted within 90 days after the date of the injury or sickness, or as soon as reasonably possible. Information to identify the insured must be provided and should include: student name, patient name, address, student ID number or social security number, birthdate, and name of the school.

A company claim form is not required, unless the itemized billing statements do not provide sufficient information to process the claim. The insured can print a company claim form or complete the online claim form from the website www.sas-mn.com.

Send claims or inquiries to:
Student Assurance Services Inc.
P.O. Box 196
Stillwater, MN 55082-0196
(800) 328-2739
www.sas-mn.com

The claim office is available for calls between 8:00 a.m. to 4:30 p.m. Central Time, Monday – Friday.

COMPLAINTS AND CLAIM APPEALS

An insured has a right to file a grievance in writing for any provision of services or claim practices of Nationwide Life Insurance Company that offers an insurance plan or its claim administration by the Plan Administrator.

If there is a problem or concern, the insured can first call the customer service toll free number on the ID card. A customer service representative will provide assistance in resolving the problem or concern as quickly as possible. If the insured continues to disagree with the decision or explanation given, a written request may be submitted for a review through the internal grievance process.

The grievance will be reviewed, and a written decision will be mailed. The grievance procedures can be obtained by contacting the Plan Administrator or by visiting our website www.sas-mn.com.

Grievances may be sent to:
Student Assurance Services Inc.
P.O. Box 196 • Stillwater, MN 55082
(800) 328-2739

PRIVACY NOTICE

Nationwide Life Insurance Company and Student Assurance Services, Inc. are committed to maintaining the privacy of the insured person's personal health information and complying with all state and federal privacy laws. A copy of the privacy notice may be obtained by contacting the Plan Administrator at (800) 328-2739 or by visiting our website www.sas-mn.com.