

SERFF Tracking Number: NWLC-125864686 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 40964
Company Tracking Number: BOO - AMENDMENT & SCHEDULE
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: College 2008 - Amendment & Schedule
Project Name/Number: /

Filing at a Glance

Company: Nationwide Life Insurance Company

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TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed State Tr Num: 40964
Sub-TOI: H04.001 Student Co Tr Num: BOO - AMENDMENT & SCHEDULE State Status: Approved-Closed

Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Authors: Bobby Handley, Jonna Shields, Shana Paladino-Ripp Disposition Date: 12/01/2008
Date Submitted: 12/01/2008 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Overall Rate Impact: Group Market Type: Blanket
Filing Status Changed: 12/01/2008
State Status Changed: 12/01/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:

This filing includes an amendment and updated schedule of benefits for a previously approved student accident and sickness filing. This schedule will replace the schedule included in the previous filing. The changes are highlighted in yellow and allow for slightly wider variable ranges and also includes additional inside limited. This has been done to accommodate smaller colleges and universities that tend to have more inside limits and lower benefits.

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The previous filing was approved on 05/16/08 and can be found under SERFF filing # NWLC-125633999.

Please let me know if you have any questions or need additional informamtion.

Thank you for your assistance with this filing.

Company and Contact

Filing Contact Information

Jonna Shields, Sr. Compliance Analyst shieldj@nationwide.com
 5525 Parkcenter Circle (614) 854-3049 [Phone]
 Dublin, OH 43017 (614) 854-3469[FAX]

Filing Company Information

Nationwide Life Insurance Company	CoCode: 66869	State of Domicile: Ohio
5525 Parkcenter Circle	Group Code: 140	Company Type:
Dublin, OH 43017	Group Name:	State ID Number:
(800) 525-8669 ext. 43508[Phone]	FEIN Number: 31-4156830	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Ohio's filing fee is \$50.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	\$50.00	12/01/2008	24214358

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/01/2008	12/01/2008

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Disposition

Disposition Date: 12/01/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *NWLC-125864686* *State:* *Arkansas*
Filing Company: *Nationwide Life Insurance Company* *State Tracking Number:* *40964*
Company Tracking Number: *BOO - AMENDMENT & SCHEDULE*
TOI: *H04 Health - Blanket Accident/Sickness* *Sub-TOI:* *H04.001 Student*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes

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Form Schedule

Lead Form Number: NSHSAS 2200-1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	NSHSAS 2200-1	Certificate Amendment, Insert Page, Endorsement or Rider	Amendment	Initial		46	NSHSAS 2200-1.pdf
Approved-Closed	NSHSAS - Schedule	Schedule Pages	Schedule of Benefits	Initial		0	Schedule of Benefits - 10-2008.pdf

NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Issues this amendment to

THE INSURED REFERRED TO ON THE COVER PAGE OF THE POLICY TO WHICH THIS
AMENDMENT IS ATTACHED AND MADE A PART THEREOF

The effective date of this amendment is the effective date of the Policy.

The Policy is amended as described below. All other terms remain unchanged.

The Extension of Benefits section of the Policy is replaced with the following:

[EXTENSION OF BENEFITS]

The Coverage provided under this Policy ceases on the termination date, shown on the face page. However, if an Insured is [Hospital Confined on the termination date from a covered Injury or Sickness for which Benefits were paid before the termination date] or [Totally Disabled on the termination date from a covered Injury or Sickness for which Benefits were paid before the termination date], Covered expenses for such Injury or Sickness will continue to be paid for a period of [thirty (30), sixty (60) ,ninety (90) days or Fifty-two (52) week benefit period] or [until date of discharge], whichever is earlier.

[With respect to the Insured, the inability to attend classes at the location where enrolled].

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

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

The Medical Necessity and Medical Appropriateness Determination section is replaced with the following:

MEDICAL NECESSITY and MEDICAL APPROPRIATENESS DETERMINATION

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

[If You have other insurance and pre-certification is required, this Coverage will consider the services authorized by the primary carrier as medically necessary and process your claim accordingly.]

If You have any questions or concerns about whether a particular service, supply, or treatment is Medically Necessary or Medically Appropriate, contact Us.

NATIONWIDE LIFE INSURANCE COMPANY

A handwritten signature in black ink that reads "Mark R. Frank". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

President

SCHEDULE OF BENEFITS

[Lifetime Aggregate Maximum*]	[10,000-1,000,000]
[Student:]	[10,000-1,000,000]
[Dependent:]	[10,000-1,000,000]
[Including Repatriation and Medical Evacuation]	
[Except treatment of an Injury resulting from a motor vehicle accident]	[5,000, 50,000-100,000]

[BASIC MEDICAL expense BENEFIT*]

Deductible, Per Sickness or Injury \$[50, 75, 100]

[The Deductible shall not apply:

- To covered x-ray services performed at the Student Health Center;
- When referred to one of the foregoing facilities by the Policyholder's Student Health Center;
- To covered Outpatient Physiotherapy rendered for treatment of Sickness at the Policyholder's Physical Therapy Health Clinic; or
- Outpatient Prescription Drugs when prescribed and filled at the Policyholder's Student Health Center]

Insured Percent [80-100]% up to \$[2,000 - 5,000] [then 100% up to the Major Medical Aggregate Maximum Amount]

Basic Aggregate Maximum Amount Per Sickness or Injury \$[1,000 - \$250,000]

Attention: If an Injury or Sickness first occurs during a Policy Year in which You select the Basic Medical Benefit plan, Covered Charges related to that Injury or Sickness will be limited to the maximum lifetime benefit amount set forth in the Basic Medical Benefit plan. This limitation will continue to apply even if You select the Enhanced Medical Benefit plan in subsequent Policy Years.

[ENHANCED MEDICAL expense BENEFIT*]

Deductible, Per Sickness or Injury \$[50, 75, 100]

[The Deductible shall not apply:

- To covered x-ray services performed at the Policyholder's Student Health service;
- When referred to one of the foregoing facilities by the Policyholder's Student Health Center;
- To covered Outpatient Physiotherapy rendered for treatment of Sickness at the Policyholder's Physical Therapy Health Clinic; or
- Outpatient Prescription Drugs when prescribed and filled at the Policyholder's Student Health Center]

Insured Percent [80-100]% up to \$[2,000-5,000] [then 100% up to the Enhanced Major Medical Aggregate Maximum Amount]

Enhanced medical Aggregate Maximum Amount Per Sickness or Injury \$[100,000 -1,000,000]

[The Basic and Enhanced Medical Benefit plans do not cover [Mental Disorders], [Outpatient Prescription Drugs prescribed for Sickness] or [Outpatient physical therapy for a Sickness] in excess of the Basic Medical Benefit plan maximum.]

Policy Year Maximum Benefit *

[Student] [\$10,000-300,000] [per Injury or Sickness]
 [Dependent] [\$10,000-300,000] [per Injury or Sickness]

Per Condition Maximum Benefit *

[Student] [\$1,000-300,000]
 [Dependent] [\$1,000-300,000]

[Except treatment of an Injury resulting from a motor vehicle accident] [5,000, 50,000-100,000]
 [Including Repatriation and Medical Evacuation]

[Pre-Notification Penalty] [0, \$250, \$500, \$750] [paid at the Out-of-Network Benefit Level]

[Pre-Certifications Penalty] [0-100]% of the applicable Network Benefit Level]] [paid at the Out-of-Network Benefit Level]

[Pre-Certification Penalty] [Payment is reduced by [\$500, 750, 1000] of the covered expense.] [paid at the Out-of-Network Benefit Level]

[If the Policy is excess, we will pay [an initial amount of [\$50, 100]] [for charges incurred [at the SHC][at the UCSF Medical Group]] for an Injury or Sickness and then we are secondary[, except Health Maintenance Organization (HMO) plans][, except for MediCal.]

[Out-of-Network claim payment - The methodology for calculating Reasonable and Customary is based upon the [50th,60th, 70th, 80th 90th] percentile of Ingenix and the prevailing rate in the community based upon zip code.

[* Combined [Student Health Center,] In-Network and Out-of-Network Benefit Levels]

	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Co-payment			
[Copayment][per office visit] [after first visit] [waived at the SHC]	[\$0-50]	[\$0-50]	[\$0-50]
[Copayments do not apply to Deductibles]			[Not applicable]
[Copayments [including Prescription Copayments] do [not] apply to the Coinsurance Maximum Limit			

[Unless otherwise indicated]

Deductible

[Deductible,] [per Policy Year], [per [Injury/] [Sickness] [Condition]] \$[0-1000] \$[0-1000] \$[0-1000]

[Unless otherwise indicated]

[waived at the SHC]

[waived in the case of an Emergency]

[A new Deductible will apply each Policy Year. However, Covered Charges incurred during the last 3 months of a Policy Year which are applied to that Covered Person's Policy Year Deductible will also be applied toward that person's Deductible for the next Policy Year and thus reduce that Policy Year's Deductible.]

[Benefits are subject to Deductibles unless otherwise indicated.]

[The Deductible is waived for the Insured Student if the Insured Student first utilizes and/or is referred by the approved university Student Health Center or if the university Student Health Center is closed.]

Expenses Incurred to meet the Deductible are cross applied [SHC], In-Network-Benefit and Out-of-Network Benefit.]

	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
[The Deductible can be met by Student and [Family] [Dependent] expenses.]	[\$0]	[\$50-2500]	[\$50-2500]
	[N/A]		
1. [Single] [Student][Covered Person] Coverage			
2. [Family] [Dependent] Coverage	[\$0]	[\$50-2500]	[\$50-2500]
	[N/A]		

Coinsurance

[Coinsurance Percentage] [except as specified herein]	[0-100%]	[0-100%][of Preferred Allowance]	[40-100%][of Reasonable and Customary expenses (R&C)]
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[Coinsurance Maximum Limit, per Policy Year]	[\$500 to \$5000]	[\$500 to \$5000]	[\$500 to \$5000]
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[Any Coinsurance paid by You is applied to the Coinsurance Maximum Limit per Policy Year]

[Any Coinsurance paid by [Student and [Family] [Dependent] is applied to the Coinsurance Maximum Limit per Policy Year]

[Once the Coinsurance Maximum Limit is reached by the Covered Person, the Coinsurance Percentage paid by the Company will be 100% In-Network and Out-of-Network.]

1. [Single] [Student][Covered Person] Coverage	[\$500 to\$5000]	[\$500 to \$6000]	[\$500 to 6000]
2. [Family] [Dependent] Coverage	[\$500 to\$5000]	[\$500 to \$6000]	[\$500 to \$6000]

[PLEASE NOTE: ALL BENEFITS ARE PER POLICY YEAR UNLESS OTHERWISE NOTED.]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Wellness Services (See Covered Services for more details)			
1. [Well Baby and child Care Age [0-18] and under]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
	[+ wavier of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[after Copayment]]	[after Copayment]	[after Copayment]
	[not covered at SHC]		[not covered Out-of-Network]
2. [Well Adult Care age [7, 17] and over	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
Maximum payment not to exceed[\$100,\$250, 500] per Policy year]	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[Adult Dependent may use the SHC for adult wellness]	[Not covered outside the SHC]	[Not covered outside the SHC]
	[Annual physical is available for Student [and adult Dependent] at SHC only]		
a. [Coverage is limited to state mandate, example mammography, pap tests, prostate exam]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[Adult Dependent may use the SHC for adult wellness]	[Not covered outside the SHC]	[Not covered outside the SHC]
	[Annual physical is available for Student [and adult Dependent] at SHC only]		

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Wellness Services (See Covered Services for more details)			
b. [One (1) annual physical] or [PPD TB Test]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[Adult Dependent may use the SHC for adult wellness]	[Not covered outside the SHC]	[Not covered outside the SHC]
	[Annual physical is available for Student [and adult Dependent] at SHC only]		
3. [Adult Immunization[--Student Only]	[100% Coinsurance]	[% Coinsurance]	[%] Coinsurance]
Includes	[after Copayment]	[after Copayment]	[after Copayment]
• [Tetanus],	[after the	[+ waiver of Deductible]	[+ waiver of Deductible]
• [Measles-Mumps-Rubella],	Deductible]	[not covered outside the SHC]	[not covered outside the SHC]
• [Travel inoculations]	[+ waiver of Deductible]		
• [Hepatitis A]	[[%] Coinsurance applied to all or select immunizations]		
• [Hepatitis B][paid at 50%]	[Adult Dependent may obtain immunizations at SHC]		
• [HPV]			
• [Flu]			
• [Pneumonia]			
• [Varicella]			
• [Meningococcal]			
• [Twinrix (combo Hepatitis A and B)]			
[up to a \$[100-500] Lifetime Aggregate Maximum]			

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Outpatient Services - (other than Maternity, Mental Health/Drug or Alcohol)			
[All Outpatient Services Maximum limit [500-15,000]]			
1. [Doctor office visits]	[Copayment]	[Copayment]	[Copayment]
a. [Evaluation and Management]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
b. [Both Professional services (Evaluation and Management) and Diagnostic services performed and billed by a Doctor's office are subject to [Copayment] [Coinsurance]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]
[Maximum visits Per [day], [injury], [illness], [sickness], [condition] [visit] limited to [1,2,3,4,5]] [after the 1,2,3,4 visits] [for sickness] [and injury]			
[Maximum We will pay Per [injury], [illness], [sickness], [condition] [visit] [\$10-1000]]			
[Specialty (other than Family Practice, Pediatrician, Internal Medicine) Physician and OB/GYN- Maximum We will pay [per visit] [per [injury], [illness], [sickness], [condition]] [2, 3, 4, 5 visits] or [\$100 - \$1000]]			
c. [Diagnostic services performed and billed by a Doctor's office]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
2. [Outpatient Health Care Facility fees]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance]
[Including, related Doctor services]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is	

Covered Services	[SHC]	established.] [In-Network Benefit Level]	[Out-of- Network Benefit Level]
Outpatient Services (other than Maternity, Mental Health/Substance Abuse)			
3. [Diagnostic Imaging and Laboratory Procedures], [x-ray and lab services which are diagnostic or therapeutic, [including ultrasounds and amniocentesis]] [up to a \$[50-,500] maximum Per [injury], [illness], [sickness], [condition]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of- Network Provider claims will be processed at the In- Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
4. [CAT Scan, MRI, and /or PET Scans] ^[1] [Maximum We will pay combined is [\$500, 700, 1000, 2000] per Injury/Sickness/Condition per Covered Person] [Maximum We will pay combined is \$[500,700,1000,2000] per [injury][illness] [sickness] [condition]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of- Network Provider claims will be processed at the In- Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Outpatient Services (other than Maternity, Mental Health/Substance Abuse)			
5. [Infusions and/or Injections]	[Copayment]	[Copayment]	[Copayment]
[Done in an Outpatient Health Care Facility or Doctor's office] ^[1]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]	[% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out- of-Network Provider claims will be processed at the In- Network benefit level once R&C is established.]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]
6. [Miscellaneous Outpatient Services]			
a. [including Radiation and Chemotherapy]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance] [after Copayment] [+ waiver of Deductible]	[% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out- of-Network Provider claims will be processed at the In- Network benefit level once R&C is established.]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]
b. [Dialysis and Filtration Procedures]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance] [after Copayment] [+ waiver of Deductible]	[% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out- of-Network Provider claims will be processed at the In- Network benefit level	[% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	once R&C is established.] [In-Network Benefit Level]	[Out-of-Network Benefit Level]
Outpatient Services			
7. [Outpatient Facility, Lab/X-ray, Emergency Room]	[Copayment]	[Copayment]	[Copayment]
[Combined services are limited to [\$100-1000] Per [injury], [illness], [sickness], [condition]]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]	[% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]
Inpatient Services ^[1]			
1. [Hospital Services]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
[Miscellaneous Hospital expenses limited to \$[500-2,000] for the first day of Hospitalization and \$[500-2,000] per day each day thereafter] [Miscellaneous Hospital expenses are limited to [\$200-\$2500] Per [injury], [illness], [sickness], [condition]]			

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Inpatient Services ^[1]			
2. [Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital.]	[Not Applicable]	[Copayment] [% Coinsurance] [50-70%] [up to \$1000-\$50,000]	[Copayment] [% Coinsurance] [50-70%] [up to \$1000-\$50,000]
[Daily Room and Board] limited to [\$100, 125, 200, 225, 250, 400, 425, 450, 500, 1000, 1500, 2000] Per [day] [injury], [illness], [sickness], [condition]		[combined Room and Board and Intensive Care Room] [Per [injury], [illness], [sickness], [condition] [hospitalization] [after Copayment] [+ waiver of Deductible] [Deductible [\$500-2000]	[combined Room and Board and Intensive Care Room] [Per [injury], [illness], [sickness], [condition] [hospitalization] [after Copayment] [+ waiver of Deductible] [Deductible [\$500-2000]
3. [Intensive Care Room]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
[Daily Room and Board limited to [\$500-\$5000] [per day] Per [injury], [illness], [sickness], [condition]			
4. [Consulting physician]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
[Up to \$[100-2500] maximum] per [injury], [illness], [sickness], [condition], [hospitalization] [Doctor visits are limited to one visit per day [includes Consulting Physician]] [does not apply when related to surgery]			

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Inpatient Services ^[1]			
5. [Doctor visit]			
[[\$10-\$100] [per visit] [per day] [1 st day only] [\$10-\$100] [per day thereafter] [up to \$100-\$500] [up to 10-30 visits] Per [injury], [illness], [sickness], [condition] [hospitalization]]			
6. [Pharmaceuticals administered while an Inpatient]	[Not Applicable]	[50-100]% of R&C	[50-100]% of R&C
7. [Skilled Nursing and Sub-Acute Care]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
[Maximum of [30-120] days], [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]			
8. [Inpatient rehabilitation (which includes physical, occupational and speech therapy)]	[Not Applicable]	[% Coinsurance] [50-70%] [up to \$5000-\$50,000] [Per [injury], [illness], [sickness], [condition] [hospitalization] [after Copayment] [+ waiver of Deductible] [Deductible [\$500-2000]] [Not Applicable] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[% Coinsurance] [50-70%] [up to \$5000-\$50,000] [Per [injury], [illness], [sickness], [condition] [hospitalization] [after Copayment] [+ waiver of Deductible] [Deductible [\$500-2000]] [Not Applicable]
[Maximum of [30-60] days], [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]			
[The maximum We will pay for Out-of-Network Inpatient rehabilitation charges is \$[500-2,000] per day, per Covered Person.]			
[Miscellaneous Hospital expenses limited to \$[500-2,000] for the first day of Hospitalization and \$[500-2,000] per day each day thereafter]			
[Miscellaneous Hospital expenses are limited to [\$200-\$2500] Per [injury], [illness], [sickness], [condition]]			

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
[Bedside visit for one companion when covered person is confined inpatient. Benefit, (travel and lodging expenses) is limited to \$[100--5,000]]			
Surgical Services ^[1]			
[up to a \$[1,000-5,000] maximum]	[%] Coinsurance	[%] Coinsurance	[%] Coinsurance
[coverage is limited to \$[250-5000] per surgery]	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
9. [Surgeon]	[%] Coinsurance	[%] Coinsurance	[%] Coinsurance
[up to a \$[1,000-5,000] maximum]	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
10. [Assistant Surgeon]	[%] Coinsurance	[%] Coinsurance	[%] Coinsurance
[coverage is limited to [20-75%] of surgeon's payment]	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment
[coverage is limited to [\$200-\$5000] per surgery]		[Up to [20- 75]% of Surgeon fees]	
[includes coverage for secondary assistant surgeon fees]		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Up to [20- 75]% of Surgeon fees]
[secondary surgeon fees are paid at 50% of Reasonable & Customary]			

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Surgical Services ^[1]			
11. Anesthesia Services [up to a \$[200-5,000] maximum] [Out-of-Network Anesthesia charges will be paid at the In-Network Benefit level if an In-Network facility and Surgeon is used.] [coverage is limited to [20-75]% of surgeon's payment]	[%] Coinsurance [%] Coinsurance after Copayment	[%] Coinsurance [%] Coinsurance after Copayment [[80-100]% of R&C] [Up to [20-75]% of Surgeon fees] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance [%] Coinsurance after Copayment [[80-100]% of R&C] [Up to [20-75]% of Surgeon fees]
12. [General Anesthesia for Dental services (See Covered Services for details)] [coverage is limited to \$[200-5000] maximum]	[%] Coinsurance [%] Coinsurance after Copayment	[%] Coinsurance [%] Coinsurance after Copayment [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance [%] Coinsurance after Copayment
13. [Outpatient Hospital/Health Care/Surgical Facility fee] [up to a \$[1,000-5,000] maximum]	[%] Coinsurance [%] Coinsurance after Copayment	[%] Coinsurance [%] Coinsurance after Copayment [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance [%] Coinsurance after Copayment [50-75%] Coinsurance
14. [Office Surgery performed in a Doctor's office]	[%] Coinsurance [%] Coinsurance after Copayment	[%] Coinsurance [%] Coinsurance after Copayment	[%] Coinsurance [%] Coinsurance after Copayment

	Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
	Surgical Services ^[1]			
15.	[Inpatient Hospital Facility Fee]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance] [%] Coinsurance after Copayment]
16.	[Oral Surgery for Accidental Injuries]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance] [%] Coinsurance after Copayment]
17.	[Reconstructive Surgery] ^[1]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance] [%] Coinsurance after Copayment]
18.	[Foot surgery]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance] [%] Coinsurance after Copayment]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Surgical Services ^[1]			
19. [Inpatient and Outpatient Miscellaneous]	[%] Coinsurance]	[%] Coinsurance]	[%] Coinsurance]
[coverage is limited to [\$500 -\$5000] per surgery]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

[No more than one surgical procedure will be covered when multiple procedures are preformed through the same incision or in immediate succession]

[When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay 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.] [[\$2,500-10,000]] allowed per surgical event]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Reproductive Services			
1. [Maternity Care] ^[1] [Coverage is limited to \$[1,000-5,000 maximum]			
a. [Pre- and Post-Natal Care, including delivery and In-Hospital Doctor visits for mother and baby]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
b. [Hospital services] ^[1]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
c. [Routine Newborn Care] [Coverage is limited to \$[500-5,000 maximum] [4 days Hospital confinement expense maximum] [Sick Newborn Care] [5-60 days Hospital confinement expense maximum]	[n/a]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Reproductive Services			
d. [Diagnostic services performed and billed by a Doctor's office, including ultrasounds and amniocentesis]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[(the 1 st ultrasound is 100%; subsequent ultrasounds are subject to Deductible & Coinsurance)]	[after Copayment]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]		
2. [Voluntary Sterilization Surgery]			
[Maximum coverage is limited to \$[100-1,000]			
a. [Performed in a Doctor's office]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[after Copayment]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]		
b. [Performed in an Outpatient Hospital]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[after Copayment]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]		
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
c. [Elective termination of pregnancy]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
[up to a \$[100-1,000] maximum]	[after Copayment]	[after Copayment]	[after Copayment]
	[after Copayment]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]		

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Mental Disorder[[not]including [Severe Mental Illness] and [Serious Emotional Disturbance of a Child]] [and Alcoholism/Drug Abuse]			
a. Outpatient Office Visits ^[1] – [10,15, 20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance]	[Copayment] [50-100% Coinsurance]	[Copayment] [40-100% Coinsurance]
[Up to a \$[500-2,500] maximum [per lifetime] [up to a \$[50-500] maximum per visit] [limited to one visit per [day][week]]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]
[For Dependents, up to a \$[500-2,500] maximum per Policy Year]			
[Partial, Residential or Day Treatment limited to [10-120 days] Per [injury], [illness], [sickness], [condition]]			
[Doctor visits for Partial, Day or Residential Treatment are limited to [1-3] visits per day]			
b. Inpatient services ^[1] - [15, 20,25,30,40,50,60,120]days,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance]	[Copayment] [[50-100]% Coinsurance]	[Copayment] [% Coinsurance]
[up to a \$[500-2,500] maximum [per lifetime]]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]
[Doctor visits limited to \$[500-2,500], after Copayment] [paid at [50-100]% up to maximum allowed]		[up to 10 continuous days and 50% thereafter up to 35 additional days (100% if certified by Review Organization)]	[up to 10 continuous days and 50% thereafter up to 35 additional days (100% if certified by Review Organization)]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
[Alcoholism/Drug Abuse][Drug Abuse [(including Severe Mental Illness and Serious Emotional Disturbance of a Child)]			
a. Outpatient Office Visits ^[1] – [20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance] [after Copayment]	[Copayment] [% Coinsurance] [after Copayment]
[\$1,000-5,000] maximum [per lifetime]	[after Copayment] [+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
b. Inpatient services ^[1] - [10, 20,30,40,50]days,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance]	Copayment] [% Coinsurance] [after Copayment]	Copayment] [% Coinsurance] [after Copayment]
[\$1,000-5,000] maximum [per lifetime]	[after Copayment] [+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[Alcoholism]^[1]			
a. [Inpatient Alcoholism services – Limit of \$[500-2,500],[per Injury] [per Sickness] [per Policy Year], [per Covered Person] [per lifetime]]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance] [after Copayment]	[Copayment] [% Coinsurance] [after Copayment]
	[after Copayment] [+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
b. [Outpatient Alcoholism services – [20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person] [per lifetime]]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance] [after Copayment]	[Copayment] [% Coinsurance] [after Copayment]
	[after Copayment] [+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
1. [Urgent Care [Non Emergency] services -Copayment waived if referred to Emergency room or admitted to Hospital within [48,72] hours]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance] [after Copayment]	[Copayment] [% Coinsurance] [after Copayment]
[Note: The [Copayment] [Deductible]] amount, if any, for this visit is waived if You are referred to an Emergency room or admitted to a Hospital for the same Condition within [forty-eight (48), seventy-two (72)] hours of the visit.]	[after Copayment] [+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[Follow up care at the Emergency room]	[Not covered]	[Not covered]	[Not covered]
2. [Emergency services -[[Copayment][ER Deductible] waived if admitted to Hospital [within [48,72] hours]] [or if Condition is life-threatening or would cause the Loss, or Loss of use, of a body part or organ] [or for treatment of a sexual assault] [includes after-hours charges]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [after \$[50-100] ER Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [after \$[50-100] ER Deductible]
[Policy Year Deductible waived in the case of an Emergency] [for Injury, treatment must be within [forty-eight (48), seventy-two (72)] hours of Accident]		[[80-100]% when immediately followed by admittance or, after a \$[50-100] Deductible, [[50-80]% when not immediately followed by admittance]	[90% in the case of life-threatening Emergency]
[Note: The [Copayment] [Deductible]] amount, if any, for this visit is waived if You are referred to an Emergency room or admitted to a Hospital for the same Condition within [forty-eight (48), seventy-two (72)] hours of the visit.]		[Emergency care services are covered at [80-100%] for Emergency treatment received with in a [25-50]-mile radius of Student Health, when Student Health is closed, if immediately followed by admittance to Hospital for Inpatient treatment).]	[[50-80]% in the case of an Emergency, if outside a [25-50]-mile radius of the Student Health Center]
[coverage is limited to [\$25-\$1000] Per [injury], [illness], [sickness], [condition] [ER Visit]]		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Emergency care services are covered at [80-100%] for Emergency treatment received with in a [25-50]-mile radius of Student Health, when Student Health is closed, if immediately followed by admittance to Hospital for Inpatient treatment).]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
3. Emergency care Doctor		[50-100]% of R&C	[50-100]% of R&C
[Maximum We will pay [per Injury] [per Sickness] [per Policy Year], [per Covered Person] [per visit] [\$25-\$1000]]		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
[Follow up care at the Emergency room]	[Not covered]	[Not covered]	[Not covered]
Other Services			
1. [Allergy services]			
a. [Allergy Testing – [[1-3]series of tests,] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]	[Not covered outside SHC]	[Not covered outside SHC]
b. [Allergy Injections][Allergy treatment]	[Copayment]	[Copayment]	[Copayment]
[includes the following: treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]	[Not covered outside SHC]	[Not covered outside SHC]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Other Services			
2. [Rehabilitative Care] -			
3. [Physical Therapy] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] [\$500-2,000] [combined] [each] [PT] [OT] [ST]] [per Condition][per Policy Year]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]
[Maximum of [5, 10, 15, 20, 25, 30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [Copayment waived for first visit] [includes chiropractic care and acupuncture] [only for a Condition that required surgery or Hospital Confinement] [except for treatment received at the SHC] [limited to one visit per day]			
4. [Speech Therapy] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit [\$500-2,000] [combined] [each] [PT] [OT] [ST]]	[% Coinsurance]	[% Coinsurance] [after Copayment]	[% Coinsurance] [after Copayment]
[Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [limited to one (1) visit per day]	[after Copayment] [+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
5. [Occupational Therapy] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit [\$500-2,000] [combined] [each] [PT] [OT] [ST]]	[%Coinsurance]	[% Coinsurance] [after Copayment]	[% Coinsurance] [after Copayment]
[Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[after Copayment] [+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
6. [Cardiac/Pulmonary] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum We will pay is \$[500-2,000] per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]	[% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
7. [Chiropractic] ^[1] [Maximum Benefit \${[Copayment] per visit; } \$[500-2,000] [combined] [each] [PT] [OT] [ST]] [per Condition][per Policy Year] [Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [[limited to one (1) visit per day]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
8. [Acupuncture] ^[1] [Maximum Benefit \${[Copayment] per visit; } \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]] [Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [[limited to one (1) visit per day]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
9. [Acupuncture and Chiropractic Combined] ^[1] [Maximum Benefit \${[Copayment] per visit; } \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]] [Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [[limited to one (1) visit per day]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
10. [Podiatry] [Maximum Benefit \${[Copayment] per visit; } \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]] [[limited to one (1) visit per day]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
11. [Home Health Care services] ^[1] [The maximum We will pay is [10-100] visits per Injury] [per Sickness] [per Policy Year], [per Covered Person] [(four (4) hours or less = one (1) visit)]	[Not Applicable]	[Copayment]	[Copayment]
OR		[% Coinsurance]	[% Coinsurance]
[The maximum We will pay is \$[50-500]per Injury] [per Sickness] [per Policy Year], [per Covered Person] [(four (4) hours or less = one (1) visit)]		[after Copayment]	[after Copayment]
		[+ waiver of Deductible]	[+ waiver of Deductible]
12. [Hospice] ^[1]	[Not applicable]	[Copayment]	[Copayment]
[The maximum We will pay for bereavement services is [60, 90] days following the Covered Person's date of death]		[% Coinsurance]	[% Coinsurance]
The maximum We will pay is [\$5000] per Injury] [per Policy Year], [per Covered Person]] [per lifetime]		[after Copayment]	[after Copayment]
		[+ waiver of Deductible]	[+ waiver of Deductible]
13. [Diabetic education] ^[1]	[Copayment]	[Copayment]	[Copayment]
[The maximum We will pay is \$[250-1,000] (per Injury) [per Sickness] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
14. [Nutrition Counseling] ^[1]	[Copayment]	[Copayment]	[Copayment]
[The maximum We will pay is \$[250-1,000] [per Sickness] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
15. [Prosthetic Appliances] ^[1]	[Copayment]	[Copayment]	[Copayment]
[The maximum We will pay for Prosthetics is \$[250-5,000][per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
16. [TMJ] [The maximum We will pay is \$[250-5,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
17. [PKU Testing & treatment]	[Not applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
18. [Durable Medical Equipment] ^[1] [The maximum We will pay is \$[100-5,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [Includes temporary surgical appliances]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
19. [Emergency Medical Transportation services] ^[1] [The maximum We will pay is \$[25-5,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [Per Trip]	[Not applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
20. [Eye Refractions, when performed in conjunction with a chronic or acute medical Condition. Note: Must be associated with an Illness code.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
21. [Repair of eye glasses, contact lens or hearing aids when required as a direct result of an Injury]	[Copayment]	[Copayment]	[Copayment]
[The Maximum We will pay is \$[25-500] [per Injury] [per Sickness] [per Condition] [per Policy Year]]	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
22. [Dental treatment due to Injury to Teeth [not including [broken fillings] [or] [damage caused by biting or chewing]	[Copayment]	[Copayment]	[Copayment]
[The Maximum We will pay is \$[100-300] per tooth] [and] \$[250-1000] per Injury]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
[treatment must be received within [5-90 days of Injury]	[after Copayment]	[after Copayment]	[after Copayment]
[Basic Plan \$[100-300]]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[Enhanced Plan \$[100-300]]		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
[Dental treatment subject to \$[50-1000] deductible]			
[\$[25-500] maximum per [impacted] [infected] wisdom tooth]			

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
23. [Blood and Body Fluid Needlestick Exposure]	[Copayment]	[Copayment]	[Copayment]
[The maximum We will pay is \$[1,000-25,000] [per exposure] [per Injury] [per Illness] [per Covered Person], [per Policy year.]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
<ul style="list-style-type: none"> • Coverage is for academic-related exposures only • No referrals needed • Covered in any geographic location in any medical facility • 100% reimbursement for: <ul style="list-style-type: none"> a. Physician visits b. Lab tests done on the Student and the patient/donor involved in the exposure c. Emergency room visits, if necessary d. Medications necessary to treat exposure 	[+ waiver of Deductible]		

[Enrollment:

1. Visiting medical Students must submit payment for this insurance Premium. The Needlestick Insurance enrollment form should be filled out and submitted with payment (by check or credit card authorization) with you visiting medical Student application. Checks should be made out to **[Nationwide Life Insurance Co]**.
2. Coverage will start the first day of the visiting medical Student's rotation, if the Premium is received by [TPA name]. The Needle-Stick Insurance enrollment form and payment should be submitted at least three weeks prior to the start date of the rotation for processing.
3. This information will be recorded in the Student Health Center (SHC) medical database and forwarded to [TPA name.], for processing.
4. An exposure (yellow) card for reference and Coverage confirmation will be given to the visiting medical Student at orientation on the first day.
5. Visiting medical Students may use the SHC for Coverage under this plan only.

Coverage under this plan will end on the last day of the visiting medical Student's rotation]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
24. [Retail Prescription Drugs - per prescription or refill [, subject to dispensing limits.]	[[30-80]% of charges] [[50-100]% after a Copayment of: \$[5-50] for each 30-day supply, \$[8-90] for each 60-day supply or \$[10-140] for each 90-day supply, if filled at SHC or if the SHC does not carry the drug, the SHC is closed, or when filled outside of a [25-50]-mile radius of the SHC] [brand name or Generic prescriptions for Accutane will be paid at [25-75]%]	[30-80% of charges] [[50-100]% after a Copayment of: \$[5-50] for each 30-day supply, \$[8-90] for each 60-day supply or \$[10-140] for each 90-day supply]	[30-80% of charges]
[Coverage is limited to [\$100 - \$1000] [\$100 - \$1000 combined generic and brand] [\$100 - \$1000 [per injury] [per sickness] [per Policy Year] [per covered person] [per cause]]			
<ul style="list-style-type: none"> Generic Drugs (Tier 1) 	[% Coinsurance after [\$0, 10,15, 20] Copayment]	[50-100% Coinsurance + waiver of Deductible after] [\$5-50] Copayment] [Accutane is subject to a [25-50]% Copayment]	[[% Coinsurance + waiver of Deductible after] [\$10, 20] Copayment] [Not covered]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
Note: Tier 2 has two option A or B			
• [Formulary Brand Drugs (Tier 2)]	[% Coinsurance after]	[% Coinsurance + waiver of Deductible after]	[% Coinsurance] [Not covered]
OR			
• [Formulary Brand Drugs, Non Formulary Brand Drugs, [Specialty Drugs (Non-Formulary, new Drugs and self injectables)] (Tier 2)]	[\$15, 20, 25, 30, 35, 50] Copayment]	[\$20, 25,35, 45, 50] Copayment] \$[10-25] in the event there is no Generic replacement for a prescribed Brand Name drug] [Accutane is subject to a [25-50]% Copayment]	
• [Specialty Drugs (Non-Formulary Brand Drugs, new Drugs, and self injectables) (Tier 3)]	[% Coinsurance + waiver of Deductible after]	[% Coinsurance + waiver of Deductible after]	[Not covered]
	You pay [30-80]% Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150- 500]]	You pay [30-80]% Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150- 500]]	
Annual maximum [\$1,000-5,000] [per Policy Year]			
[Only a 30 day supply can be dispensed at any time.]			
[One (1) Copayment per thirty (30) day supply]]			
[includes prescription contraceptives] [Prescriptions for [anti-fungal nail and nail pad medication/Therapy, including but not limited to] Lamisil and Sporanox are not covered.] [anti-malarials for prophylaxis are covered] [The Deductible [, excess provision,] and Pre-existing Condition Limitation are waived for prescriptions filled at the SHC [, for a drug the SHC does not carry or when filled outside of a [25-50]-mile radius of the SHC].]			
[Diabetic Supply Benefit – Annual maximum, separate from the pharmacy benefit maximum [\$500,1000,1500,2000]]	[% Coinsurance after [\$0, 10,15, 20] Copayment]	[50-100% Coinsurance + waiver of Deductible after]	[[% Coinsurance + waiver of Deductible after]
The following supplies are covered:			[\$10, 20]
<ul style="list-style-type: none"> • Blood glucose testing device, including those designed to assist the visually impaired (one every three years) • Blood glucose testing strips • Ketone urine testing strips • Lancets and lancet puncture devices • Pen delivery systems for the administration of insulin • Insulin syringes] 		[\$10, 20, 25, 35, 45, 50] Copayment]	[Not covered]

Covered Services	[SHC]	[In-Network Benefit Level]	[Out-of-Network Benefit Level]
25. [Mail Service Prescription Drugs - per prescription or refill, [subject to dispensing limits 30 days, 60 days, 90 days]. (In-Network Benefit only)]			
<ul style="list-style-type: none"> Generic Drugs (Tier 1) 	Not applicable	[% Coinsurance + waiver of Deductible after] \$[10-50] Copayment]	Not covered
Note: Tier 2 has two option A or B			
<ul style="list-style-type: none"> [Formulary Brand Drugs (Tier 2)] 	Not applicable	[% Coinsurance + waiver of Deductible after] \$[25-100] Copayment]	Not covered
Or			
<ul style="list-style-type: none"> [Formulary Brand Drugs, Non Formulary Brand Drugs, [Specialty Drugs (Non-Formulary, new Drugs and self injectables)] (Tier 2)] 			
<ul style="list-style-type: none"> [Specialty Drugs (Non-Formulary Brand Drugs, new Drugs, and self injectables) (Tier 3)] 	Not applicable	[% Coinsurance + waiver of Deductible after] You pay [30-80%] Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150-500] for a 30 day supply]	Not covered
[Medical Evacuation [to home [state] [country]] The maximum We will pay is \$[5000-25,000] per Policy Year, per Covered Person]			
[Family companion benefit is limited to \$[1,000-5,000]] [Medical treatment provided in the home country, if not covered by any other coverage is covered at [[50 th ,60 th , 70 th , 80 th 90 th] percentile of R&C up to [\$250-\$5000] maximum]			
[Repatriation of Remains The maximum We will pay is \$[5000-10,000] per Covered Person]			
[Family companion benefit is limited to \$[1,000-5,000]]			

SERFF Tracking Number: *NWLC-125864686* *State:* *Arkansas*
Filing Company: *Nationwide Life Insurance Company* *State Tracking Number:* *40964*
Company Tracking Number: *BOO - AMENDMENT & SCHEDULE*
TOI: *H04 Health - Blanket Accident/Sickness* *Sub-TOI:* *H04.001 Student*
Product Name: *College 2008 - Amendment & Schedule*
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

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Filing Company: Nationwide Life Insurance Company State Tracking Number: 40964
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Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 12/01/2008

Comments:

Attachments:

Certification of Compliance.pdf
Read Cert.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 12/01/2008

Comments:

NSHSAS 2300 and NSHSAS 2800 both approved on 05/16/2008 under SERFF filing # NWLC-125633999.

CERTIFICATION OF COMPLIANCE

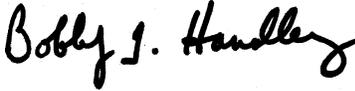
Name and Address of Insurer:

Nationwide Life Insurance Company
Special Risks Underwriting
5525 Parkcenter Circle
Dublin, OH. 43017-3584
Mail Code: CO-03-30

Policy/Certificate Form Number(s):

NSHSAS 2200-1 Amendment
NSHSAS – Schedule Schedule of Benefits

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with Arkansas Rule/Regulation 19, Arkansas Rule/Regulation 49 and the Consumer Information Notice as outlined in ACA 23-79-138.


Bobby Handley
Assistant General Counsel

Date: December 1, 2008

CERTIFICATION OF COMPLIANCE WITH
INSURANCE POLICY SIMPLIFICATION REQUIREMENTS

Name and Address of Insurer:

Nationwide Life Insurance Company
Special Risks Underwriting
5525 Parkcenter Circle
Dublin, OH. 43017-3584
Mail Code: CO-03-30

Policy/Certificate Form Number(s):

NSHSAS 2200-1	Amendment
NSHSAS-Schedule	Schedule of Benefits

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with the Flesch reading ease score and the other requirements set forth in the Insurance Policy Language Simplification Act of the State of Arkansas.



Tom DeNoma
Associate Vice President

Date: December 1, 2008