Student Health Insurance Plan

Designed for the Students of

BROWN

2014-2015

NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Policy Number: 302-120-3812

Group Number: S210207

IMPORTANT NOTICE

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

NONDISCRIMINATORY

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

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PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentially of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at (800) 633-7867 or by visiting us at: www.chpstudent.com.

INTRODUCTION

THE BROWN UNIVERSITY STUDENT HEALTH INSURANCE PLAN

The Brown University Student Health Insurance Plan is designed to protect against unexpected medical expense and to meet most students' needs while on campus and throughout the Policy Year. Often a student covered by a Health Maintenance Organization (HMO) or a managed care policy at home, has limited or no benefits while at the University, in other parts of the U.S. or in a foreign country. When reviewing your current policy, check to ensure that it provides access to healthcare providers in the Brown University area and provides comprehensive coverage, extending beyond emergency care to include hospitalization (including room and board, physicians' fees, surgical expenses), lab tests, x-rays, prescription drugs, mental health care, and sports injuries.

This brochure is a brief description of the Plan. The exact provisions governing the insurance are contained in the Master Policy issued to Brown University and may be viewed at school during regular business hours. This Plan is underwritten by Nationwide Life Insurance Company and is serviced by University Health Plans. Claims are processed by Consolidated Health Plans.

STUDENT ELIGIBILITY AND ENROLLMENT

All registered full-time or part-time students enrolled in a degree-granting program, who are not enrolled exclusively in online courses, are automatically enrolled in the Student Health Insurance Plan described in this brochure. Participation in this Student Health Insurance Plan is required by vote of the Corporation of the University unless a Waiver is completed and submitted each academic year by the Waiver deadline. Special students registered for courses who are not automatically enrolled in the Student Health Insurance Plan may be eligible for coverage. Contact the Insurance Office prior to the start of the semester. This Plan supplements Health Services located in Andrews House, 13 Brown Street. Health Services is operated solely by Brown University and is not affiliated with the Insurance Company.

Students must actively attend classes for at least the first thirty-one (31) days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes.

The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

WAIVER PROCEDURES

Students who do not want to participate in the Student Health Insurance Plan must complete a Waiver by the deadline confirming participation in a comparable health insurance plan that will be in effect until August 15, 2015.

Students will need to complete and submit an online Waiver. To access the Waiver, log on to www.univhealthplans.com, click on Brown University and then the Waiver icon in the menu section. In order to waive coverage, you will need to know the name of your current insurance carrier, insurance carrier's claims address, toll-free customer service telephone number, policyholder's name, policyholder's ID number and group name or number if applicable.

Immediately upon submitting the Online Waiver, you will receive a confirmation email that the Online Waiver has been submitted. Print this confirmation email for your records, as it is your proof that the Online Waiver was submitted. If you do not receive a confirmation email, the Waiver was not submitted and you will need to correct any errors on the Online Waiver and resubmit it. Should you have questions, please contact University Health Plans at (800) 437-6448.

WAIVER DEADLINE

The deadline for ALL students to complete and submit the Waiver for annual coverage is June 1, 2014. For students who are newly enrolled students for second semester coverage, the waiver deadline is January 1, 2015. Students who do not complete and submit the Waiver by the printed deadline will be automatically enrolled in the Student Health Insurance Plan and the fee will remain on their student account.

QUALIFYING EVENTS

Students who waive coverage under the Brown University Student Health Insurance Plan, and then subsequently lose coverage under their private insurance plan during the academic year, may be eligible to enroll in the Student Health Insurance Plan. Students can only enroll in the Student Health Insurance Plan if they have lost coverage due to a qualifying event, such as a change in employment or marital status, or attaining the age limit of their insurance plan. Students will be required to submit a Qualifying Event Form and supporting documents to provide proof of termination to University Health Plans within thirty-one (31) days of the qualifying event. Enrollment in the Student Health Insurance Plan is not automatic. Students will be charged the full premium for the applicable term of coverage; the premium will not be pro-rated.

Students enrolled in the Brown University Student Health Insurance Plan who become eligible for health insurance coverage for the first time as a dependent on an alternative, comparable plan, may be eligible to terminate their enrollment in the Student Health Insurance Plan. Eligibility for termination must be due to a change in employment or marital status. Students will be required to submit a Qualifying Event Form and supporting documents to provide proof of first time eligibility to University Health Plans within thirty-one (31) days of the qualifying event. Refund of premium will be pro-rated accordingly, minus the cost of any claim benefits made by Us.

LEAVE OF ABSENCE COVERAGE

Students who take a leave of absence (i.e. personal, medical or to study away from Brown University) and who have been previously insured under the Student Health Insurance Plan for the enrollment period immediately prior to taking the leave of absence are eligible to enroll in the Student Health Insurance Plan for a maximum of one (1) year. Interested students should contact the Insurance Office about their eligibility, and need to submit an application and premium to University Health Plans prior to August 15, 2014.

DEPENDENT ELIGIBILITY AND ENROLLMENT

Students may enroll their eligible Dependents at additional cost. Dependent means: the spouse (husband or wife or domestic partner, including same sex civil union partners) of the Insured Student and their dependent children up to age twenty-six (26). Newborn infant means any child born of an Insured Student or Spouse while that person is insured under this Policy. Newborn Infants will be covered under the Policy for the first thirty-one (31) days after birth. Coverage for such a child will be for Injury or Sickness including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent. Only the Insured Student will have the right to continue such coverage for the child beyond the first thirty-one (31) days. If the Insured Student does not use this right as stated here, all coverage as to that child will terminate at the end of this first thirty-one (31) days after the child's birth. A newborn child of an Insured Student's dependent child is not eligible to continue coverage beyond the initial thirty-one (31) day period. To continue the coverage the Insured Student must, within thirty-one (31) days after the child's birth, complete and return the Dependent Enrollment Form with payment to University Health Plans. Students also have the option of enrolling their eligible dependents online at www.univhealthplans.com.

Domestic Partner means the partner of an Insured Student who has filed a "Declaration of Domestic Partnership" for same-sex Domestic Partners or a "Common Law Marriage Affidavit" for opposite-sex Domestic Partners with the Insurance Office and who: (a) has been residing with the Insured Student for at least six (6) consecutive months, and intends to do so indefinitely; (b) is considered the Insured Student's "sole Domestic Partner"; (c) is, along with the Insured Student, at least eighteen (18) years of age; (d) is, along with the Insured Student, jointly responsible for each other's welfare and financial obligations; and (e) is, along with the Insured Student, not married or related by blood.

Party to a Civil Union means a person who has established a civil union according to applicable state law.

Students can contact either the Insurance Office or University Health Plans to obtain Dependent enrollment forms and applicable plan cost, or log on at www.univhealthplans.com to enroll their eligible Dependents online. Eligible Dependents need to be added by September 15, 2014 for an effective date of August 15, 2014 to be continuously insured and avoid a break in coverage. Dependents are not automatically re-enrolled in the plan. It is the student's responsibility to ensure the timely enrollment of eligible Dependents each Policy Year. Students who are newly enrolled at Brown for the Spring Semester must enroll their eligible Dependents by February 15, 2015 for an effective date of January 15, 2015 and students who are newly enrolled at Brown for the Summer Semester must enroll their eligible dependents by July 1, 2015 for an effective date of June 1, 2015.

QUALIFYING EVENTS

Outside of these enrollment periods, eligible Dependents can only be added to the plan within thirty-one (31) days of a qualifying event such as marriage, spouse's initial arrival to the United States, birth of a child, or loss of coverage due to a change in employment status. The qualifying event can occur anytime during the Policy Year, however, the Insured must notify Us in writing within thirty-one (31) days of the qualifying event and pay the required additional premium in order to be eligible for coverage.

POLICY TERMS AND PLAN COSTS

The insurance under Brown University's Student Health Insurance Plan for the Annual Policy is effective 12:01 a.m. on August 15, 2014. An eligible student's coverage becomes effective on that date or the date the application and full premium are received by the University or University Health Plans, whichever is later. The Annual Policy terminates at 12:01 a.m. on August 15, 2015 or at the end of the period through which the premiums are paid, whichever is earlier.

The insurance for Spring Coverage is effective on 12:01 a.m. on January 15, 2015 or the date the application and full premium are received by the University or University Health Plans, whichever is later and terminates at 12:01 a.m. on August 15, 2015, whichever is earlier.

The insurance for Summer Coverage is effective on 12:01 a.m. on June 1, 2015 or the date the application and full premium are received by the University or University Health Plans, whichever is later and terminates at 12:01 a.m. on August 15, 2015, whichever is earlier.

	Annual Cost 8/15/14-8/15/15	**Spring Cost** 1/15/15-8/15/15	**Summer Cost** 6/01/15-8/15/15
Student	$3,225*	$1,917*	$678
Spouse / Domestic Partner	$2,841	$1,686	$594
Child(ren)	$2,841	$1,686	$594
Spouse/ Domestic Partner & Child(ren)	$5,068	$3,004	$1,066

* Rates above include a $26 administrative fee for Annual Coverage, or a $15 administrative fee for Spring Coverage, or a $6 administrative fee for Summer Coverage. The administrative fee is retained by the school.

This Policy is a Non-Renewable One (1) Year Term Policy.

PREMIUM REFUND POLICY

Except for a withdrawal due to an Injury or Sickness, any Insured Student withdrawing from the University during the first thirty-one (31) days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of the premium will be made minus the cost of any claim benefits made by Us. Insured Students withdrawing after thirty-one (31) days will remain covered under the Plan for the full period for which the premium has been paid and no refund will be made available. This is true for students on leave for medical or academic reasons and students electing to enroll in a separate comparable plan during the Policy Year. Premium received by the Company is fully earned upon receipt.

Insured Students experiencing a qualifying event or graduating in December may request a pro-rated premium reimbursement by contacting the Insurance Office in writing within thirty-one (31) days of the qualifying event or from the completion of their degree requirements. Coverage for an Insured Student entering the Armed Forces of any country will terminate as of the date of such entry. Those Insured Students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request.

HEALTH SERVICES

For Medical Care: Call (401) 863-3953

Patients are seen by appointment only; same day appointments available.

Academic Year

Monday – Thursday: 9:20 am to 6:20 pm

Friday: 9:20 am to 4:20 pm

Saturday and Sunday: 10:00 am to 3:30 pm

Winter / Spring Break / Summers

Monday – Friday: 9:20 am to 4:20 pm (3:20 pm in the summer)

Closed Weekends and Thanksgiving Break

Emergency Care: Call (401) 863-4111

Emergency care is available 24 hours/7 days per week. Call the Department of Public Safety for Brown Emergency Medical Services (EMS).

Health Services is open Monday through Friday, 8:30 am to 5:00 pm (4:00 pm in the summer) for administrative needs.

Health Services provides the following services:

- Primary care of medical problems
- 24/7 medical advice
- X-rays/Labs on site (billed services)
- Pharmacy on site (billed service)
- Allergy Injection Service (billed service)
- Rhode Island Mandated Immunizations for students entering college in Rhode Island (billed service)
- Dermatology Clinic (during the academic year only)
- Health Education
- EMS and Ambulance Service

Hours of operation and services available are subject to change. Please refer to the Health Services website at www.brown.edu/health for the most current information.

During Summer and Vacation Breaks:

Hours of operation and available services vary. Emergency care is still available 24 hours/7 days per week through the Dept of Public Safety at 863-4111. Please refer to the website for the most current information.

PSYCHOLOGICAL SERVICES

J Walter Wilson, Room 516
To make an appointment, call (401) 863-3476 during regular office hours.

Academic Year
Monday – Friday 8:30 am to 5:00 pm
Closed Nights, Weekends, and Holidays. Call (401) 863-3476 to reach an on-call clinician.

Winter / Spring Break
Office is closed. Call (401) 863-3476 to reach an on-call clinician.

Summers (July and August)
Office is closed. Patients are seen by appointment.

Call Health Services at (401) 863-3953 during regular office hours.

Psychological Services provides the following services:

- Short-term Psychotherapy (7 sessions/academic year)
- Referral to clinicians in Providence community for on-going treatment
- Medication consultation and management for students in on-going psychotherapy
- Mental health crisis intervention
- Crisis response for students who have been sexually assaulted
- Support groups
- Consultation regarding students of concern

STUDENT HEALTH INSURANCE BENEFITS

This Plan provides benefits based on the type of health care provider You or Your covered Dependent select. This Plan provides access to a PPO with Preferred Providers/facilities locally and nationwide. If You or Your covered Dependent receives care from a Preferred Provider, this Plan will pay for any Covered Medical Expense at the Preferred Provider level of benefits. If a Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. If care is received from an Out of Network Provider, this Plan will pay seventy percent (70%) for any Covered Medical Expense at the Out of Network Provider level of benefits. All payments will be subject to any applicable Deductible, Coinsurance, Maximum Benefits, and other provisions or limitations in this Plan. Eligible Expenses are payable in accordance with the Schedule of Benefits outlined in this brochure.

PREFERRED PROVIDER INFORMATION

The Brown University Student Health Insurance Plan provides access to hospitals and health care providers, who participate in Preferred Provider Networks, both locally and across the country. The advantage to using Preferred Providers is that these providers have agreed to accept a predetermined fee or Preferred Allowance as payment in full for their services. Consequently, when Insured Persons use Preferred Providers, out-of-pocket expenses will be less because any applicable coinsurance will be based on a Preferred Allowance.

The Insured Person should be aware that Preferred Provider Hospitals might be staffed with Out of Network Providers. As a result, receiving services or care from an Out of Network Provider at a Preferred Provider Hospital does not guarantee that all charges will be paid at the Preferred Provider level of benefits. The participation of specific providers in the Preferred Provider Networks is subject to change without notice. Insured Persons should always confirm when making an appointment that the provider participates in a Preferred Provider Network.

First Health Network is the Preferred Provider Network and provides access to providers located across the United States. To determine if a provider participates in First Health, students can call (800) 226-5116 or visit www.firsthealth.com. It is important that Insured Persons verify that their providers are Preferred Providers each time they call for an appointment or at the time of service.

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

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for covered medical expenses.

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

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

DEFINITIONS

Whenever used in this Plan:

CO-PAYMENT: A specified dollar amount a Covered Person must pay for specified charges.
COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the Policy; 4) made for services included in the Schedule of Benefits; 5) made for services and supplies which are a Medical Necessity; 6) in excess of the amount stated as a Deductible, if any. Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this Policy as a Deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The Deductible will apply per Policy Year as specified in the Schedule of Benefits.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States. This does not include services that are medically necessary.

EMERGENCY means 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.

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

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate dependent premium has been paid. The term "Insured" also means Insured Person.

MEDICAL NECESSITY - 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.

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;
- involves a service, supply or drug not considered reasonable and necessary by the Centers for Medicare & Medicaid Services; or
- 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.

Except for Preventive Care (Wellness Services), all Covered Services must be Medically Necessary. If You have any questions or concerns about whether a particular service, supply, or treatment is Medically Necessary or Medically Appropriate, contact Us.

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

OUT OF POCKET MAXIMUM is the most You pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. This limit will never include Premium, balance-billed charges or health care Your Policy does not cover.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family. The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PREFERRED ALLOWANCE means the amount a Preferred Provider will accept as payment in full for covered services.

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

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

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

   See http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm for *USPSTF A and B Recommendations.*

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

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

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

SICKNESS means Illness, disease or Condition, including pregnancy and Complications of Pregnancy that impairs a Covered Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness**.**

STUDENT means a full-time or part-time student enrolled in a degree-granting program at a school, who is not enrolled exclusively in online courses and whose enrollment does not consist entirely of Short-Term Courses. Home study, correspondence, online, and television (TV) courses do not fulfill the Eligibility requirements.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges which is defined as the 80th percentile of Fair Health, Inc. Prevailing Healthcare Charges Systems.

WE, US and OUR means Nationwide Life Insurance Company.

YOU and YOUR means the Insured Person.

SCHEDULE OF BENEFITS

If care is received from a Preferred Provider any Covered Medical Expense will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level benefits. Reduced or lower benefits will be provided when an Out of Network Provider is used. The benefits payable are as defined in and subject to all provisions of this Policy and any endorsements thereto. Benefits will be paid up to the Policy Year Maximum Benefit. Covered Medical Expenses included:

BENEFIT	PREFERRED PROVIDERS	OUT OF NETWORK PROVIDERS
Policy Year Maximum Benefit	**Unlimited**	
*** Deductible[1] (Applies to Preferred Providers and Out of Network Providers)**	$300 Deductible (per Policy Year) (per Insured Person) This Deductible does **not** apply to the following benefits: • Emergency Room Visits • Diagnostic X-Rays and Laboratory Tests, when ordered by University Health Services • Outpatient Mental Health Visits • Outpatient Physician Office Visits • Outpatient Prescription Drugs • Other Outpatient Services when provided by University Health Services $100 Deductible (Per Policy Year) (Per Insured Person) for inpatient hospitalization or outpatient surgery performed at a hospital or hospital-affiliated surgical center. This Deductible is in addition to the $300 Deductible (per Policy Year) (per Insured Person).	
Out-of-Pocket Maximum (per Policy Year) • Includes Copayments; Deductibles & Prescription Drug Copayments; • Excludes non-covered medical expenses & Elective services; • Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year; • Once the Out-of-Pocket Limit is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100%.	**$6,350 per insured** **$12,700 Family Maximum**	
INPATIENT EXPENSE Once the Deductible(s) has been met, Covered Medical Expenses will be paid as indicated below.		
Room and Board*[1], daily semi-private room rate; general nursing care provided by the Hospital, or intensive care unit	100% of Preferred Allowance	70% of Usual and Customary (U&C) Charges

* Deductible(s) applies as described above.

1 Refer to plan detail for limitations, exclusions, and definitions.

BENEFIT	PREFERRED PROVIDERS	OUT OF NETWORK PROVIDERS
Hospital Miscellaneous*[1], such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services, and supplies	100% of Preferred Allowance	70% of U&C Charges
Routine Newborn Care*[1]	Paid as any other Sickness, 48/96 hours maximum	
Surgery*[1], including Assistant Surgeon and Anesthetist services and Multiple Surgical Procedures	100% of Preferred Allowance	70% of U&C Charges
Physician Visit*[1]	100% of Preferred Allowance	70% of U&C Charges
Pre-Admission Testing*[1]	100% of Preferred Allowance	70% of U&C Charges
Registered Nurse*[1]	80% of U&C Charges	70% of U&C Charges
OUTPATIENT EXPENSE Once the Deductible(s) has been met, Covered Medical Expenses will be paid as indicated below.		
Surgery*[1], including Assistant Surgeon and Anesthetist services and Multiple Surgical Procedures	100% of Preferred Allowance	70% of U&C Charges
Outpatient Miscellaneous*[1], includes all diagnostic x-rays, laboratory testing, MRIs, CAT scans, radiation therapy, chemotherapy, and other medically necessary treatment.	100% of Preferred Allowance	70% of U&C Charges
Urgent Care Facilities*[1]	$25 Co-pay, then 100% of Preferred Allowance	$25 Co-pay, then 70% of U&C Charges
Emergency Room[1] (must be a Medical Emergency[1] or Accident). Emergency Room visits can result in both Preferred Provider and Out of Network charges	$100 Co-pay, then 100% of Preferred Allowance. Co-pay waived if admitted.	$100 Co-pay, then 100% of U&C Charges. Co-pay waived if admitted.
Physician's Visit[1], including but not limited to: routine eye exams, hearing tests, speech tests, gynecological visits (outside of preventive), allergists and dermatologists.	$15 Co-pay per office visit, then 100% of Preferred Allowance	$15 Co-pay per office visit, then 70% of U&C Charges
Preventive/Wellness Care & Immunizations*[1]	100% of Preferred Allowance; Deductible does not apply to preferred providers for preventive care.	70% of U&C Charges

* Deductible(s) applies as described on page 13.

1 Refer to plan detail for limitations, exclusions, and definitions.

BENEFIT	PREFERRED PROVIDERS	OUT OF NETWORK PROVIDERS
Chiropractic Care*[1], services include 12 treatments per Policy Year (Massage Therapy is excluded unless provided by MD)	$10 Co-pay per visit, then 100% of Preferred Allowance	$10 Co-pay per visit, then 70% of U&C Charges
Habilitative & Rehabilitative Physiotherapy (Physical Therapy) / Occupational Therapy*[1], includes Massage Therapy when performed by MD.		
• After an inpatient hospitalization	• 100% of Preferred Allowance	• 70% of U&C Charges
• After an ambulatory care surgery	• 100% of Preferred Allowance	• 70% of U&C Charges
• After a specific Injury or Sickness	• 80% of Preferred Allowance	• 70% of U&C Charges
OTHER EXPENSES Once the Deductible(s) has been met, Covered Medical Expenses will be paid as indicated below.		
Maternity/Complication of Pregnancy*[1]	Paid as any other Sickness	
Voluntary Termination of Pregnancy*[1]	Paid as any other Sickness	
Ambulance Service*[1]	80% of U&C Charges	70% of U&C Charges
Reimbursement for Nurse Practitioner*[1]	100% of Preferred Allowance	70% of U&C Charges
Accidental Dental*[1] Treatment for Injury to sound, natural teeth	80% of U&C Charges	70% of U&C Charges
Pediatric Dental for Covered Persons under Nineteen (19) *[1]		
• Preventive & diagnostic services	100% of U&C Charges	
• Basic restorative services	70% of U&C Charges	
• Major restorative services	50% of U&C Charges	
• Medically Necessary Orthodontia	50% of U&C Charges	
Waiting periods and other limitations may apply. Benefits are subject to the medical deductible and out-of-pocket maximum.		
Routine Vision Exam for Covered Persons under Nineteen (19) *[1]	$15 Co-pay per office visit, then 100% of PA	$15 Co-pay per office visit, then 70% of U&C Charges
• Limited to one exam/fitting per Policy Year		
• Includes prescription eyeglasses (lenses or frames) or contact lenses in lieu of eyeglasses, limited to once per Policy Year	100% of U&C Charges up to $150, 50% thereafter	
Prosthetic Appliance and Orthotic Device*[1]	100% of Preferred Allowance	70% of U&C Charges

* Deductible(s) applies as described on page 13.

1 Refer to plan detail for limitations, exclusions, and definitions.

BENEFIT	PREFERRED PROVIDERS	OUT OF NETWORK PROVIDERS
Consultant*[1]	Paid same as Physician's Visit	
Durable Medical Equipment*[1]	80% of U&C Charges	70% of U&C Charges
Hospice Care*[1]	100% of Preferred Allowance	70% of U&C Charges
Skilled Nursing Facility*[1]	100% of Preferred Allowance	70% of U&C Charges
Prescription Drugs[1], To minimize your out of pocket expense, prescriptions should be filled at an Express Scripts participating pharmacy. Visit www.express-scripts.com for participating pharmacies. Deductibles do not apply. Co-pays apply to a 30 day fill or refill.	$0 Co-pay for generic contraceptives; $15 Co-pay for generic drugs; $30 Co-pay for preferred brand name drugs; or $50 Co-pay for non-preferred brand name drugs.	If a non-Express Scripts pharmacy is used, you will need to pay for prescription and submit receipts for reimbursement based on Express Script's preferred pricing.
Sexual Reassignment Surgery/Gender Identity Disorder *[1]	Paid as any other Sickness	
Obesity (Bariatric) Surgery*[1]	Paid as any other Sickness	
Organ Transplant *[1]	Paid as any other Sickness	
Treatment outside of the United States*[1]	70% of U&C Charges	
Medical Evacuation, Return of Mortal Remains, and Global Emergency Medical Assistance Services*[1]	Paid to Policy Maximum; Assistance Services provided by FrontierMEDEX and must be approved in advance by FrontierMEDEX.	
STATE MANDATED BENEFITS (Please refer to plan detail for description of State Mandated Benefits) Once the Deductible(s) has been met, Covered Medical Expenses will be paid as indicated below, subject to State Mandated Benefit limits.		
Benefits for Autism Spectrum Disorder*[1], for covered persons up to age 15, for applied behavior analysis, physical therapy, speech therapy and occupational therapy services.	Paid as any other Sickness	
Benefits for Prescribed Contraceptive Drugs and Devices*[1]	Paid as any other Sickness; Co-pays/Deductibles do not apply to generic contraceptives.	
Benefits for Diabetes Treatment*[1]	Paid as any other Sickness	
Benefits for Early Intervention Services[1]	100% of Preferred Allowance	70% of U&C Charges
Benefits for Hearing Aids *[1]	Paid as any other Sickness	
Benefits for Home Health Care*[1]	100% of Preferred Allowance	70% of U&C Charges

* Deductible(s) applies as described on page 13.

1 Refer to plan detail for limitations, exclusions, and definitions.

BENEFIT	PREFERRED PROVIDERS	OUT OF NETWORK PROVIDERS
Benefits for Human Leukocyte Antigen or Histocompatibility Locus Antigen Testing*[1]	Paid as any other Sickness	
Benefits for Treatment of Infertility*[1]	100% of Preferred Allowance	70% of U&C Charges
Benefits for Screening for Lead Poisoning*[1]	100% of Preferred Allowance; Deductible does not apply for preventive care.	70% of U&C Charges
BENEFIT	**PREFERRED PROVIDERS**	**OUT OF NETWORK PROVIDERS**
Benefits for Treatment of Lyme Disease*[1]	Paid as any other Sickness	
Benefits for Mammography and Pap Smear*[1]	100% of Preferred Allowance; Deductible does not apply for preventive care.	70% of U&C Charges
Benefits for Mastectomy, Reconstructive Surgery and Prosthetic Devices*[1]	Paid as any other Sickness	
Benefits for Treatment of Inpatient Mental Health and Substance Abuse*[1]	Paid as any other Sickness	
Benefits for Outpatient Mental Health[1], Included is testing for Attention Deficit Disorder.	$15 Co-pay, then 100% of Preferred Allowance	$15 Co-pay, then 70% of U&C Charges
Benefits for Outpatient Substance Abuse*[1]	100% of Preferred Allowance	70% of U&C Charges
Benefits for New Cancer Therapies*[1]	Paid as any other Sickness	
Benefits for Off-Label Drug Use for Cancer Treatment*[1]	Paid as any other Prescription Drug	
Benefits for Pediatric Preventive Care*[1]	100% of Preferred Allowance; Deductible does not apply for preventive care.	70% of U&C Charges
Benefits for Postpartum Care*[1]	Paid as any other Sickness	

***** Deductible(s) applies as described on page 13.

1 Refer to plan detail for limitations, exclusions, and definitions.

BENEFIT	PREFERRED PROVIDERS	OUT OF NETWORK PROVIDERS
Benefits for Prostate and Colorectal Cancer Screening*[1]	100% of Preferred Allowance; Deductible does not apply for preventive care.	70% of U&C Charges
Benefits for Smoking Cessation*[1]	100% of Preferred Allowance; Deductible does not apply for preventive care.	70% of U&C Charges
Benefits for Scalp Hair Prosthesis[1], Limit one (1) per Policy Year	Paid as any other Sickness	
Benefits for Enteral Formulas*1	Paid as any other Sickness	
Benefits for Services of Licensed Midwives*1	Paid as any other Sickness	
Benefits for Certified Counselors in Mental Health*[1]	Paid as any other Sickness	

***** Deductible(s) applies as described on page 13.

1 Refer to plan detail for limitations, exclusions, and definitions.

COVERED MEDICAL EXPENSES

Your health care services under this Plan are listed below. In order for these services and supplies to be considered Covered Medical Expenses, they must be:

1. Authorized by a Physician;
2. Rendered and billed by a Physician or provider; and
3. Medically Necessary, except as specified.

Inpatient Expense: The following inpatient Hospital services are covered:

- **Room and Board:** We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits, for a semi-private room containing two (2) or more beds, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a newborn nursery, special care, or intensive care unit.
- **Hospital Miscellaneous:** We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits for the following Hospital Miscellaneous Expenses:
  - (a) anesthesia, anesthesia supplies and services;
  - (b) operating, delivery and treatment rooms and equipment;
  - (c) diagnostic x-ray and laboratory tests;
  - (d) oxygen tent;
  - (e) blood and blood services;
  - (f) prescribed drugs and medicines;
  - (g) medical and surgical dressings, supplies, casts and splints;

(h) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy;
(i) physical and occupational therapy; and
(j) other necessary and prescribed Hospital expenses.

- **Surgery:** When, by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient basis, We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits, for the Surgery, in connection with any one surgical procedure. Surgical Expense means charges by a Physician for: a) a surgical procedure; b) necessary preoperative treatment during a Hospital stay in connection with such procedure; and c) usual post-operative treatment. This benefit includes expenses related to newborn circumcision.
- **Multiple Surgical Procedures:** When an 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 Medical Expense of the most expensive surgical procedure then being performed, and with regard to the less expensive surgical procedure in an amount equal to fifty percent (50%) of the Covered percentage of the Covered Medical Expense for these procedures.
- **Anesthesia:** If, in connection with such operation, the Insured Person requires the services of an anesthetist, We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits.
- **Assistant Surgeon:** If, in connection with such operation, the Insured Person requires the services of an Assistant Surgeon, We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits.
- **Physician's Visit:** When, by reason of Injury or Sickness, an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Physician, who may or may not have performed the surgery on the Insured Person, We will pay the covered percentage of the Covered Medical Expense incurred for such services, as shown in the Schedule of Benefits. The following medical services performed by a Physician are covered on an inpatient basis: a) limited to one (1) Physician visit per day b) constant care and treatment while an Insured Person is confined in an intensive care unit; c) care by two (2) or more Physicians during one Hospital stay when the Insured Person's condition requires the skill of separate Physicians; d) consultation by another Physician when requested by the Insured Person's Physician. Coverage is limited to one (1) consultation per admission. Staff consultations required by Hospital rules are not covered.
- **Consultant Visit:** If, by reason of Injury or Sickness, an Insured Person requires the service of a consultant or specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis, We will pay the covered percentage of the Covered Medical Expense incurred as shown in the Schedule of Benefits.
- **Pre-Admission Testing:** This Plan shall provide for reimbursement of charges made by a Hospital for use of its outpatient facilities for tests ordered by a Physician. The tests must be performed as a planned preliminary to the Insured Person's admission as an inpatient for surgery in that same Hospital. However: a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; c) the surgery actually takes place within seven (7) days of pre-surgical tests; and d) the Insured Person is physically present at the Hospital for the tests. What We pay is shown in the Schedule of Benefits.
- **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital confined; 3) ordered by a licensed Physician; and 4) a medical necessity. General nursing care provided by the Hospital is not covered under this benefit.

Outpatient Expense

- **Surgery:** When, by reason of Injury or Sickness, an Insured Person requires surgery on an outpatient basis, We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits, for the Surgery, in connection with any one (1) surgical procedure. Surgical Expense means charges by a Physician for: a) a surgical procedure; b) necessary preoperative treatment during a Hospital stay in connection with such procedure; and c) usual post-operative treatment. This benefit includes expenses related to newborn circumcision.
- **Multiple Surgical Procedures:** When an 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 Medical Expense of the most expensive surgical procedure then being performed, and with regard to the less expensive surgical procedure in an amount equal to fifty percent (50%) of the covered percentage of the Covered Medical Expense for these procedures.
- **Anesthesia:** If, in connection with such operation, the Insured Person requires the services of an anesthetist, We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits.
- **Assistant Surgeon:** If, in connection with such operation, the Insured Person requires the services of an Assistant Surgeon, We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits.

Outpatient Miscellaneous: If, by reason of Injury or Sickness, an Insured Person incurs expenses in a Physician's office, Hospital outpatient department, emergency room, clinical lab, radiological facility, or other similar facility licensed by the state, We will pay the covered percentage of the Covered Medical Expense incurred for Outpatient Services as shown in the Schedule of Benefits.

Covered Medical Expense for Outpatient Services are charges for the following services, and are paid as shown in the Schedule of Benefits:

(a) a Physician's office visit, while not Hospital Confined, (does not apply when related to surgery or physiotherapy. Benefits are limited to one (1) visit per day);
(b) chiropractic care (limited to one (1) visit per day);
(c) a Hospital outpatient department, urgent care facility or emergency room;
(d) diagnostic x-ray and laboratory testing;
(e) blood and blood services, if provided and billed by a Hospital or other facility;
(f) physical and occupational therapy following inpatient hospitalization, ambulatory care surgery or after a specific Injury or Sickness;

(g) radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy, biofeedback;

(h) radiological lab or other similar facility licensed by the state;

(i) annual routine eye exam;

(j) annual routine physical and GYN exam;

(k) HPV Vaccine (age 19- 26);

(l) wellness/preventive immunizations that are required to meet federal regulations under the Affordable Care Act (ACA):

Vaccines for adults--doses, recommended ages, and recommended populations vary:

- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

Vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

(m) required immunizations for students entering college in Rhode Island;

(n) hearing and speech tests;

(o) allergy testing and allergy extracts; or

(p) acupuncture.

Maternity Benefit: We will pay benefits for an Insured Person's Covered Charges for maternity care, including hospital, surgical and medical care. We cover charges for a minimum of forty-eight (48) hours of inpatient care following an uncomplicated vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother makes a decision for an earlier discharge from the

Hospital. For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for one (1) home health care visit if prescribed by the attending Doctor. For a mother and newborn child who have a shorter Hospital stay, We will pay for one (1) home visit scheduled within twenty-four (24) hours after Hospital discharge; and an additional home visit if prescribed by an attending provider.

Newborn Infant Care: Newborn infant care is covered for the first thirty-one (31) days after birth. This benefit does not include circumcision (refer to Surgery Benefit). This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility. Charges for home visits are not subject to any Deductible, Coinsurance or Co-payments. We cover such charges the same way We treat Covered Charges for any other Sickness.

Voluntary Termination of Pregnancy: If, as a result of pregnancy, an Insured Person has a voluntary abortion, We will pay the covered percentage of the Covered Medical Expense incurred as shown in the Schedule of Benefits. Expenses for the voluntary abortion must be incurred while this Plan is in force as to the Insured Person.

Ambulance Services: When, by reason of Injury or Sickness, an Insured Person requires the use of a community or hospital Ambulance in a Medical Emergency, We will pay the covered percentage of the Covered Medical Expense incurred as shown in the Schedule of Benefits. "Ambulance Service" is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered services appropriate to the condition. If there is no such facility available, coverage is for the trip to the closest facility outside the local area. Air transportation is covered when a Medical Necessity because of a life threatening Injury or Sickness. "Air Ambulance" is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

Reimbursement for Nurse Practitioners: We cover charges for the services of a certified registered Nurse Practitioner and psychiatric and mental health Nurse Clinical Specialist practicing in collaboration with or in the employ of a licensed Physician. Services provided must be within the certified registered Nurse Practitioner's or psychiatric and mental health Nurse Clinical Specialist's area of expertise as established by education and certification, and are currently reimbursed when rendered by any other licensed health care provider. What We pay is shown in the Schedule of Benefits.

Accidental Dental: When an Insured Person incurs expenses for dental treatment for Injury to sound natural teeth, We pay the covered percentage of the Covered Medical Expense incurred as shown in the Schedule of Benefits.

Pediatric Dental for Covered Persons Under Age Nineteen (19): Payment for dental treatment as shown in the Schedule of Benefits: Benefits are subject to the medical deductible and out-of-pocket maximum.

(a) Preventive & diagnostic services, for Covered Persons under age nineteen (19); Limited to two (2) exams / prophylaxis / topical fluoride treatments per Policy Year. Includes:

- x-rays – bitewing
- x-rays - full-mouth and panoramic – one (1) per thirty-six (36) months

- sealants (as needed for permanent 1st and 2nd molars only, one (1) per tooth every thirty-six (36) months)
- space maintainers

(b) Basic restorative services, for Covered Persons under age nineteen (19). Includes:

- Emergency palliative treatment of pain
- Fillings (amalgam, resin-based composite)
- Simple extractions

(c) Major services, for Covered Persons under age nineteen (19).

- Benefits shall be subject to all Deductible, Co-payment, coinsurance, limitations, or any other provisions of the Policy.

(d) Pediatric Dental – Medically Necessary orthodontia services, for Covered Persons under age nineteen (19).

- Medically Necessary Orthodontics means the patient must have a severe and handicapping malocclusion. This means the child's condition must be severe enough to impact their ability to function such as having trouble eating and/or speaking.
- Benefits shall be subject to all Deductible, Co-payment, coinsurance, limitations, or any other provisions of the Policy.

Routine Vision Exam for Covered Persons Under Age Nineteen (19): Limited to one (1) exam/fitting per Policy Year. Includes prescription eyeglasses (lenses or frames) or contact lenses in lieu of eyeglasses, limited to once per Policy Year. Benefits are paid as shown in the Schedule of Benefits.

Prosthetic Appliance and Orthotic Device: If, by reason of Injury or Sickness, an Insured Person requires the use of a Prosthetic Appliance or Orthotic Device, We will pay the covered percentage of the Covered Medical Expense incurred by the Insured Person for such Medical Equipment, as shown in the Schedule of Benefits. Replacement of Prosthetic Appliance and Orthotic Device is covered when a Medical Necessity.

- **Prosthetic Appliance** means a device, or artificial appliance, that: a) maintains or replaces the body part of an Insured Person whose covered Injury or Sickness has required the removal of that body part; and b) is prescribed by the Insured Person's Physician who documents the necessity for the item.
- **Orthotic Device** means a mechanical device, such as braces or shoes, that: a) is directly related to the treatment of an Injury or Sickness; and b) is prescribed by the Insured Person's Physician who documents the Medical Necessity for the item.

Durable Medical Equipment: If, by reason of Injury or Sickness, an Insured Person requires the use of Durable Medical Equipment, We will pay the covered percentage of the Covered Medical Expense incurred by the Insured Person for such Durable Medical Equipment, as shown in the Schedule of Benefits. We pay the Covered Medical Expense incurred by the Insured Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental.

Hospice Care: When, by reason of Injury or Sickness, an Insured Person requires Hospice care, We will pay the covered percentage of the Covered Medical Expense incurred by the Hospice for palliative and supportive care furnished to a terminally ill Insured Person under a written "hospice care program". We cover any services and supplies, including prescription

drugs, to the extent they are otherwise covered by this Plan. Services and supplies may be furnished on an inpatient and outpatient basis. Hospice benefits are limited to a maximum of six (6) months. If the benefit is exhausted, an Insured Person may apply for an extension of benefits. Limited extensions will be granted if the Insured Person is facing imminent death.

Skilled Nursing Facility: If an Insured Person requires continuing treatment in a Skilled Nursing Facility or a Rehabilitation Center following hospitalization, We will pay the covered percentage of the Covered Medical Expense incurred as shown in the Schedule of Benefits by the Insured Person for treatment in such Skilled Nursing Facility or Rehabilitation Center. We cover room and board, routine nursing care and other services and supplies during the confinement including physical therapy, speech therapy and occupational therapy. The services must be a Medical Necessity as a continuation of treatment for the condition for which the Insured Person was previously hospitalized. The Insured Person must be admitted to the Skilled Nursing Facility or Rehabilitation Center within twenty–four (24) hours following a Medically Necessary Hospital stay. We cover such charges the same way We treat Covered Medical Expense for any Hospital Confinement.

Sexual Reassignment Surgery/Gender Identity Disorder: We will provide benefits for Sexual Reassignment Surgery/Gender Identity Disorder subject to the benefits and limitations in the Policy. Treatment includes: Mental Health Counseling (subject to Mental Health Inpatient/Outpatient benefit limitations) Hormone replacement therapy (subject to the pharmacy benefit limitations) Gender reassignment surgery is limited to the following surgeries:

Female to Male: Mastectomy, Hysterectomy, Salpingo-oophorectomy, Vaginectomy, Metoidioplasty, Scrotoplasty, Urethroplasty, Placement of testicular prostheses, Phalloplasty.

Male to Female: Orchiectomy, Penectomy, Vaginoplasty, Clitoroplasty, Labiaplasty.

Organ Transplant: The following transplants, including organ acquisitions, hospital services, related services and supplies which are determined to be Medically Necessary for the treatment of a Condition are covered: Solid organs, including but not limited to: autologous and allogenic bone marrow transplants, autologous and allogenic stem cell transplants. In addition, coverage is provided for anything caused by, contributed to, or resulting from an organ transplant, including complications thereof.

DENTAL SAVINGS PLAN

The Dental Savings Program is an exclusive plan for students enrolled in the Student Health Insurance Plan. The program is operated by Connection Dental Network to provide students access to general and specialty dental care from a select network of local dentists. The network of providers has met strict credentialing and quality assurance requirements. The network of participating dental providers has agreed to accept negotiated prices for the services they provide. Students will be responsible for paying for services they receive at the time of the visit. Students will generally save from twenty to fifty percent (20% - 50%) of charges for a wide range of dental services – from routine cleanings to root canals. Because the Dental Savings Program is not insurance, there are no claim forms, annual maximums, benefit limitations and conditions or other plan provisions. Students can log onto the website, www.ppousa.com to locate participating dental providers. Nationwide Life Insurance Company does not underwrite this plan.

VISION SAVINGS PLAN

For Vision Discount benefits please go to www.chpstudent.com.

NURSE HOTLINE FOR STUDENTS

For quick, sound medical advice from specially trained Nurses, 24 hours a day, 365 days per year, call toll free at 800-557-0309.

PRESCRIPTION DRUG BENEFIT

The Prescription Program is available through the Express Scripts (which includes the Health Services Pharmacy) and is based on their national preferred drug formulary, as well as a three (3) tier Co-payment structure. There is a $15 Co-payment for a thirty (30) day supply of a generic drug, a $30 Co-payment for a thirty (30) day supply of a preferred brand name drug, and a $50 Co-payment for thirty (30) day supply of a non-preferred brand name drug. Co-payments do not apply to generic contraceptives. After the Co-payment, the prescription will be covered at 100% included in the Policy Year maximum benefit. In order to maximize your benefits under this prescription plan, we encourage you to ask your physician to consult the drug formulary.

Prescriptions must be filled at an Express Scripts Participating Pharmacy. Present your ID card to the pharmacist when purchasing your prescription. If a prescription needs to be filled prior to receiving an ID card, reimbursement will be made upon receipt of a completed prescription drug claim form. To locate a participating pharmacy or obtain current information on the preferred drug formulary, call Express Scripts at (800) 451-6245 or log onto www.express-scripts.com. **Please note that the formulary is subject to change.** In the event that you reach the maximum benefit allowed under the student insurance plan, you can still use your student insurance/prescription ID card to fill your prescriptions at an Express Scripts participating pharmacy. Although you can no longer pay a simple Co-payment in order to receive outpatient prescription drugs by showing your card at the time of filling a prescription, you will be charged the plan's preferred prescription pricing, rather than the retail prescription cost. Please show your student insurance ID card to the pharmacist at the time of purchase to receive the plan's preferred pricing. The prescription drug benefit includes hormone therapy for transgender transition. Not all prescription drugs are covered. Prescriptions such as legend vitamins or food supplements; immunization agents (except preventive/pediatric immunizations); drugs to promote or stimulate hair growth; experimental drugs; or drugs dispensed at a rest home are not covered under the Prescription Drug Benefit.

STUDY/TRAVEL ABROAD

Whether studying or traveling abroad, the Student Health Insurance Plan provides the same benefits as if you were on campus, in addition to Return of Mortal Remains, Emergency Medical Evacuation and Global Emergency Medical Assistance. These services are coordinated through FrontierMEDEX, the 24-hour worldwide assistance service and must be approved in advance by FrontierMEDEX in order to be covered. When studying or traveling abroad, keep your identification card with you and take a copy of the brochure for reference. When outside of the United States, you will likely be asked to pay for your medical care first and then will need to seek reimbursement. Covered Expenses will be reimbursed on an Out of Network basis, after any applicable Co-payments or Deductibles. When you submit claims

for reimbursement, you will need to have the itemized bill(s) translated into English and include a letter informing the claims administrator that you are seeking reimbursement for charges previously paid. Please ensure that your name, ID number, address (to receive your reimbursement check), and the University's name are on the bill.

RETURN OF MORTAL REMAINS

In the event of the death of an Insured Person, The Plan will pay the actual charges incurred for preparing and transporting that person's remains to his or her home country. This will be done in accord with all legal requirements in effect at the time the body remains are to be returned to his or her home. The death must occur while the person is insured for this benefit. Return of Mortal Remains must be approved in advance by FrontierMEDEX.

EMERGENCY MEDICAL EVACUATION

The Plan will pay benefits for the Usual and Customary Charge incurred if any Injury or Sickness results in the Emergency Evacuation of the Insured Person.

Emergency Evacuation means: after being treated at a local Hospital; the Insured Person's medical condition warrants transportation to his/her home country to obtain further medical treatment to recover.

Covered Expenses are expenses for transportation, medical services and medical supplies necessarily incurred in connection with an Emergency Evacuation of the Insured Person. All transportation arrangements made for evacuating the Insured Person must be: a) by the most direct and economical conveyance; and b) approved in advance by FrontierMEDEX.

Transportation means any land, water or air conveyance required to transport the Insured Person during an Emergency Evacuation. Expenses for special transportation must be: a) recommended by the attending physician; or b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to; Air Ambulance, land Ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Physician.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

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

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

If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center. FrontierMEDEX will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

Key Services Include:

1. Medical Consultation, Evaluation and Referrals
2. Foreign Hospital Admission Guarantee
3. Emergency Medical Evacuation
4. Critical Care Monitoring
5. Medically Supervised Repatriation
6. Prescription Assistance
7. Transportation to Join Patient
8. Care for Minor Children Left Unattended Due to a Medical Incident
9. Return of Mortal Remains
10. Emergency Counseling Services
11. Lost Luggage or Document Assistance
12. Interpreter and Legal Referrals

STATE MANDATED BENEFITS

Benefits shall be subject to all Deductible, Co-payment, coinsurance, limitations, or any other provisions of the Policy.

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

AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Sickness and is subject to medical necessity and appropriateness. Coverage is provided for applied behavior analysis, physical therapy, speech therapy occupational therapy services, and psychology, psychiatry and pharmaceutical services for the treatment of Autism spectrum disorders. Benefits shall continue until the covered person reaches age fifteen (15).

"Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvements in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

BENEFITS FOR CONTRACEPTIVES

Benefits will be paid for prescription contraceptive drugs and devices approved by the Food and Drug Administration (FDA). Benefits will not be provided for the Prescription Drug RU 486.

BENEFITS FOR DIABETES TREATMENT

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the treatment of all types of diabetes, if recommended or prescribed by a Physician. Benefits shall include coverage for the following equipment and supplies for the treatment of diabetes: blood glucose monitors and blood glucose monitors for the legally

blind, test-strips for glucose monitors and/or visual reading, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices, and oral agents for controlling blood sugar and therapeutic/molded shoes for the prevention of amputation.

Benefits will also be provided for the expense incurred for the education as to the proper self-management and treatment of the diabetic condition, including information on proper diet. Benefits shall be limited to visits Medically Necessary upon diagnosis of diabetes by a Physician or a significant change in the Insured Person's symptoms or conditions which necessitate changes in the Insured Person's self management; and upon determination of a Physician the re-education or refresher education is necessary. Diabetes self-management education shall be provided by a Physician. Coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when medically necessary.

BENEFITS FOR EARLY INTERVENTION SERVICES

Benefits will be paid as designated below, exclusive of any Deductibles or coinsurance, for Early Intervention Services. Any amount paid under this benefit shall not be applied to any annual or maximum lifetime benefit contained in the Policy.

The Company shall reimburse certified Early Intervention providers, who are designated as such by the Department of Human Services, for Early Intervention Services at rates of reimbursement equal to or greater than the prevailing integrated state/Medicaid rate for Early Intervention Services as established by the Department of Human Services.

"Early Intervention Services" means, but is not limited to, speech language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for Dependents from birth to age three (3) who are certified by the Department of Human Services as eligible for services under part C of the individuals with disabilities education act (20 U.S.C. sec. 1471 et seq.).

BENEFITS FOR HEARING AIDS

Benefits will be paid for an individual hearing aid, per ear. Hearing aid means any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including but not limited to FM devices. Benefits may be subject to managed care, Medical Necessity, or utilization review.

BENEFITS FOR HOME HEALTH CARE

Home Health Care services will be provided for the care and treatment of a covered Injury or Sickness provided that the following definition applies and the following limitations are observed. "Home Health Care" is defined as a Medically Necessary program to reduce the length of a Hospital stay or to delay or eliminate an otherwise Medically Necessary Hospital admission. The Home Health Care program must be formulated and supervised by the Insured Person's Physician, and must not exceed six (6) home or Physician's office visits per month, three (3) nursing visits per week, and twenty (20) hours of home health aide visits per week.

Benefits include the following services as needed: physical or occupational therapy as a rehabilitative service, respiratory service, speech therapy, medical social work, nutrition counseling, prescription drugs and medication, medical and surgical supplies, such as

dressings, bandages, and casts, minor equipment such as commodes and walkers, laboratory testing, x-rays and E.E.G. and E.K.G. evaluations. Communicable diseases and Mental Illness are excluded from Home Health Care coverage.

BENEFITS FOR HUMAN LEUKOCYTE ANTIGEN OR HISTOCOMPATIBILITY LOCUS ANTIGEN TESTING

Benefits will be paid the same as any other Sickness for human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. Benefits shall include the costs of testing for A, B or DR antigens. Benefits will be limited to one (1) test per Insured per lifetime. The Insured must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

BENEFITS FOR THE TREATMENT OF INFERTILITY

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Infertility. "Infertility" means the condition of an otherwise presumably healthy married woman between the ages of twenty-five (25) and forty-two (42) who is unable to conceive or sustain a pregnancy during a period of one (1) year.

BENEFITS FOR SCREENING FOR LEAD POISONING

Benefits will be paid for screening tests for lead poisoning for children under six (6) years of age, including but not limited to confirmatory blood lead testing. Benefits are not payable where the child is eligible for benefits from the Department of Human Services.

BENEFITS FOR TREATMENT OF LYME DISEASE

Benefits will be paid the same as any other Sickness for diagnostic testing and long-term antibiotic treatment recommended by a Physician for treatment of chronic Lyme disease. Benefits will not be denied solely because treatment may be characterized as unproven, experimental or investigational in nature.

BENEFITS FOR MAMMOGRAPHY AND PAP SMEAR

Benefits will be paid for mammograms and pap smears in accordance with the guidelines established by the American Cancer Society. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under this Policy.

Reimbursement for mammograms will be made only if the facility in which the mammogram has been taken and processed and the licensed Physician interpreting the mammogram both meet state-approved quality assurance standards for taking, processing and interpreting mammograms.

Reimbursement for pap smears will be made only if the laboratory in which the pap smear is processed is licensed by the Rhode Island Department of Health specifically to perform cervical cytology, or is accredited by the American Society of Cytology, or is accredited by the College of American Pathologists, or is a Hospital accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association at the time the pap smear is processed.

BENEFITS FOR MASTECTOMY, RECONSTRUCTIVE SURGERY AND PROSTHETIC DEVICES

Benefits will be paid the same as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured for an axillary node dissection or a Mastectomy for the treatment of breast cancer. Benefits will be paid for a

minimum of forty-eight (48) hours of inpatient care following a Mastectomy and a minimum of twenty-four (24) hours after an axillary node dissection. If the Insured in consultation with the Physician chooses to be discharged earlier than the time period stated for the applicable procedure, benefits will be paid for a minimum of one (1) home visit conducted by a Physician or Registered Nurse.

Benefits will be paid the same as any other Sickness for reconstructive surgery performed after a Mastectomy. Benefits will be paid for Prosthetic Devices and reconstruction to produce a symmetrical appearance. Benefits will be paid for prostheses and treatment of physical complications, including lymphademas, at all stages of Mastectomy, in consultation with the attending Physician and the patient.

"Mastectomy" means the removal of all or part of the breast to treat breast cancer, tumor, or mass.

"Prosthetic Devices" means and includes the provision of initial and subsequent prosthetic devices ordered by the Insured's Physician.

BENEFITS FOR TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE

Mental Illness means any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization and that substantially limits the life activities of the person with the illness, provided, however, that tobacco and caffeine are excluded from the definition of "substance" for the purposes of this Policy. Mental Illness shall not include: a) mental retardation, b) learning disorders, c) motor skills disorders, d) communication disorders, and e) mental disorders classified as "V" codes.

Benefits will be paid the same as any other Sickness for the treatment of Mental Illness and Substance Abuse. Benefits will include inpatient hospitalization, partial hospitalization provided in a Hospital or any other licensed facility, intensive outpatient services, Outpatient Services and Community Residential Care Services for Substance Abuse treatment. Benefits will not include methadone maintenance services or Community Residential Care Services for Mental Illnesses other than Substance Abuse disorders.

Outpatient Services for the treatment of Mental Illness will be paid the same as any other Sickness.

Outpatient Services for Substance Abuse Treatment will be paid the same as any other Sickness. "Outpatient Services" means office visits that provide for the treatment of Mental Illness and Substance Abuse. "Community Residential Care Services" means those facilities as defined and licensed in accordance with Rhode Island Title 40.1, Chapter 24.5.

BENEFITS FOR NEW CANCER THERAPIES

Benefits will be paid the same as any other Sickness for new cancer therapies still under investigation when the following circumstances are present:

1. Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI) Community clinical oncology programs; the Food and Drug Administration (FDA) in the form of an Investigational New Drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;

2. The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);
3. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
4. The patients receiving the investigational treatment meet all protocol requirements;
5. There is no clearly superior, non-investigational alternative to the protocol treatment; and
6. The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as successful as the non-investigational alternative.

The coverage of new cancer therapy treatment provided pursuant to a Phase II clinical trial will not be required for only that portion of that treatment provided as part of the phase II clinical trial; and is otherwise funded by a national agency, such as the National Cancer Institute, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any portions of a Phase II trial which are customarily funded by government, biotechnical and/or pharmaceutical and/or medical device industry sources in Rhode Island or in other states will continue to be so funded in Rhode Island and coverage pursuant to this section shall supplement, not supplant, customary funding.

Benefits will not be paid for new cancer therapy treatment under this provision for that portion of the treatment in connection with a Phase II clinical trial that is funded by a national agency or by commercial organizations.

BENEFITS FOR OFF-LABEL DRUG USE FOR CANCER TREATMENT

Benefits will be paid the same as any other Prescription Drug for any Drug prescribed to treat an Insured for cancer if the Drug is recognized for treatment of such indication in one of the Standard Reference Compendia or in Medical Literature. Benefits will not be paid for a) any Drug not fully licensed or approved by the FDA, b) the use of any Drug when the FDA has determined that use to be contraindicated, or c) any experimental Drug not otherwise approved for any indication by the FDA. Benefits will include services associated with the administration of such Drugs.

"Standard Reference Compendia" means a) the United States Pharmacopeia Drug Information; b) the American Medical Association Drug Evaluations; or c) the American Hospital Formulary Service Drug Information. "Medical Literature" means published scientific studies published in at least two (2) articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal. "Drug" means the primary anti-cancer or antineoplastic agent or agents.

BENEFITS FOR ORTHOTIC AND PROSTHETIC SERVICES

Coverage is provided for orthotic and prosthetic devices that equal benefits provided under federal laws for health insurance for the aged and disabled. Coverage is limited to the most appropriate model that adequately meets the Covered Person's needs as determined by the treating physician.

Prior authorization for orthotic and prosthetic devices is required in the same manner that prior authorization is required for any other covered benefit. Repair and replacement of orthotic or

prosthetic devices is subject to Co-payments and Deductibles, unless necessitated by misuse or loss.

BENEFITS FOR PEDIATRIC PREVENTIVE CARE

Benefits will be paid for the cost of Pediatric Preventive Care Services provided for the ages specified below.

"Pediatric Preventive Care Services" are those services recommended by the committee on practice and ambulatory medicine of the American Academy of Pediatrics when delivered, supervised, prescribed or recommended by a Physician and rendered to a child from birth through age nineteen (19). All such services must be in keeping with the prevailing medical standards. Benefits are payable on a per visit basis to one (1) health care provider per visit.

BENEFITS FOR POSTPARTUM CARE

Benefits will be paid the same as any other Sickness for the expense of postpartum care. Benefits will be provided for a minimum of forty-eight (48) hours of in-patient care following a vaginal delivery and a minimum of ninety-six (96) hours of in-patient care following a caesarean section for a mother and her newly born child including routine well-baby care. Any decision to shorten such minimum stay will be made by the attending Physician in consultation with the mother and will be made in accordance with the standards for guidelines for perinatal care published by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics. If the stay is less than the minimum, post-delivery care shall include home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests, or any other tests or services consistent with the guidelines.

BENEFITS FOR PROSTATE AND COLORECTAL CANCER SCREENING

Benefits will be paid for prostate and colorectal examinations and laboratory tests for cancer for any nonsymptomatic Insured in accordance with the current American Cancer Society guidelines.

BENEFITS FOR TOBACCO CESSATION TREATMENT

We will pay the covered percentage of the Covered Medical Expense incurred, as shown in the Schedule of Benefits, tobacco cessation treatments including outpatient counseling for smoking cessation when provided by a qualified practitioner. We will also include coverage for nicotine replacement therapy or prescription drugs.

Nicotine replacement therapy includes but is not limited to nicotine gum, patches, lozenges, nasal spray and inhalers.

Smoking cessation treatment, as used in this regulation, includes the tobacco dependence treatments identified as effective in the most recent clinical practice guideline published by the United States Department of Health and Human Services for treating tobacco use and dependence.

Coverage is subject to copayments and/or deductibles for smoking cessation treatment consistent with the policy's copayments and/or deductibles for physician services and medications.

BENEFITS FOR SCALP HAIR PROSTHESIS

Benefits will be paid for hair loss suffered as a result of the treatment of any form of cancer or leukemia subject to the same limitations and guidelines as other prostheses and limited to one (1) per covered member per year, exclusive of any Deductible.

BENEFITS FOR ENTERAL FORMULAS

Benefits will be paid the same as any other Sickness for nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein.

BENEFITS FOR AMBULANCE SERVICES

Benefits will be paid for ground ambulance services; co-payments will not exceed a $50 Co-payment. Ground Ambulance Services means those services provided by an ambulance service licensed to operate in Rhode Island in accordance with section 23-4.1-6. The term excludes air and water ambulance services and ambulance services provided outside of Rhode Island.

BENEFITS FOR SERVICES OF LICENSED MIDWIVES

Benefits will be provided for licensed midwives if the services provided are within the licensed midwives' area of professional competence and are currently reimbursed when rendered by any other licensed health care provider.

CERTIFIED COUNSELORS IN MENTAL HEALTH

Benefits will be paid for the services of counselors in mental health licensed pursuant to § 5-63.2-9 and therapists in marriage and family practice licensed pursuant to § 5-63.2-10 excluding marital and family therapy unless the individual is diagnosed with a mental disorder.

EXCLUSIONS OR LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Policy or for newborn or adopted children;
2. Custodial care, care provided in: rest homes, health resorts, homes for the aged, halfway houses or places mainly for domicillary or custodial care;
3. Dental treatment (except as provided for Covered Persons under age 19), and except for accidental Injury to sound, natural teeth as specifically provided in the Schedule of Benefits;
4. Elective Surgery or Elective Treatment, except as specifically provided;
5. Eye refractions, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses, (except as provided for Covered Persons under age 19), vision correction surgery or other visual defects and problems except when due to a disease process;
6. Foot care including: flat foot conditions, subluxations of the foot, care of corns, calluses, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
7. Hearing and speech tests, except as specifically provided;
8. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
9. 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;

10. Investigational services, except as specifically provided;
11. Marriage, family and group counseling, except as specifically provided under Mental Illness Expense;
12. Vaccinations, inoculations and preventive shots: a) required for travel; b) required for employment; except specifically listed immunizations provided herein.
13. Under the Prescription Drug Benefit, when included, any drug or medicine:
    (a) Obtainable Over the Counter (OTC);
    (b) For the purpose of weight control;
    (c) Anabolic steroids used for body building;
    (d) Sexual enhancement drugs;
    (e) Cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in this Policy;
    (f) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
    (g) For an amount that exceeds a ninety (90) day supply;
    (h) Purchased after Coverage under the Policy terminates;
    (i) If the FDA determines that the drug is:
    - Contraindicated for the treatment of the Condition for which the drug was prescribed; or
    - Experimental for any reason.
14. Reproductive services including but not limited to: premarital examinations; vasectomy; reversal of sterilization procedures; except as specifically provided in the benefits for the treatment of Infertility;
15. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
16. Skeletal irregularities of one or both jaws, non-surgical temporomandibular joint dysfunction;
17. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);
18. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
19. Weight management, weight reduction, nutrition programs, treatment for obesity, except for surgery for morbid obesity.

SUBROGATION AND RECOVERY RIGHTS

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for Benefits made by the Company to or for benefit of an Insured Person. The Insured shall

execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

EXTENSION OF BENEFITS

The coverage provided under this Policy ceases on the Termination Date. 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, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed twelve (12) months after the Termination Date. 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.

COORDINATION OF BENEFITS (COB)

This section will be used to determine an Insured Person's benefits under this Plan if the Insured Person is insured for medical care benefits under this Plan and is also covered for these benefits under other Plans. This section will also address the benefits that would be paid by this Plan, without this COB section plus the benefits that would be paid by the other Plans, without a COB section similar to this section would exceed allowed expenses as defined below.

Please note that other health insurance plans may not recognize this plan as one that they will coordinate benefits with. If you are covered under another health insurance plan as well, and your other plan does not coordinate benefits with student health plans, your other coverage will be primary and your student health plan will pay on an excess basis.

Plan means a plan, which provides benefits or services for, or by reason of, medical, or dental care or treatment through:

1. group, blanket, franchise, or subscriber insurance coverage;
2. pre-paid plans for: a) group hospital service; b) group medical service; c) group practice; d) individual practice; and e) any other such plans for members of a group;
3. any plan provided by: a) labor management trusts; b) unions; c) employer organizations; d) professional organization; or e) employee benefit organizations;
4. a government program or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
5. any group or group type hospital indemnity of more than $100 per day; and
6. Medicare (Title XVII of the Social Security Act); and

7. any group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

A Plan does not include individual or family insurance contracts; individual or family subscriber contracts; individual or family coverage through Health Maintenance Organizations (HMO's); individual or family coverage under other prepayment, group practice and individual practice plans; group or group-type hospital indemnity benefits of $100 per day or less; blanket school accident-type coverages; a state plan under Medicaid, or any plan when, by law, its benefits are excess to those of any private insurance program or other nongovernmental program.

Rules to Determine Which Plan Pays First: A plan, or part of one, that does not have a COB section similar to this section will pay its benefits before a plan that has such a section. In all other cases, the plan that will pay its benefits first will be:

1. The plan, which covers the Insured Person as an employee rather than as a full or part time student. Item 1 will not apply unless a similar provision is contained in all plans. In this case item 2, 3 or 4 will determine which plan pays first.
2. If 1 does not apply, the plan, which covers the person as a full or part-time student rather than as a dependent.
3. If 1 and 2 do not apply, the plan, which covers the person as a dependent of the parent whose month and date of birth occurs earlier in the year. If the other plan has a rule based on the gender of the parent, the gender rule will determine the order of benefits. However, a child's parents may be divorced or separated. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with custody rather than as a dependent of the parent without custody. If the parent with custody remarries: a) the plan, which covers the child as a dependent of a parent with custody will pay its benefits first; b) the plan, which covers the child as a dependent of a stepparent will pay its benefits next; and c) the plan, which covers the child as a dependent of a parent without custody will pay its benefits last. A court decree may require the parent without custody to be financially responsible for the child's health care. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with such responsibility rather than as a dependent of any other person.
4. If 1, 2, or 3 do not apply, the plan, which has covered the insured person for the longer time rather than the shorter time.

CONTINUATION PLAN

Students currently insured under this Health Insurance Plan whose eligibility ends due to graduation or otherwise leaving school are eligible to continue coverage under a Continuation Plan, subject to its terms and conditions. Enrollment for this Continuation Plan must be made by calling University Health Plans at (800) 437-6448.

CLAIM PROCEDURES

In the event of an Injury or Sickness the Insured Student should:

1. If at Brown University, report immediately to Health Services or Psychological Services for proper treatment; or
2. If away from Brown University or if Health Services or Psychological Services is closed, consult a Physician and follow his/her advice.
3. A claim form is not required to submit a claim. However, an itemized medical bill, HCFA 1500, or UB92 form should be used to submit expenses. The Insured Student/Person's name and identification number need to be included.
4. The form(s) should be mailed **within ninety (90) days** from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to the Claims Administrator, Consolidated Health Plans Inc., at the address listed on page 38 of this brochure.
5. If your treatment is a result of an accident you will receive an accident form from Consolidated Health Plans, Inc. and be asked to provide additional information in order to process the claim. If there is question as to whether another insurance plan may be applicable to any treatment received, you may also receive written notification from Consolidated Health Plans, Inc. and be asked to provide information on any other insurance plan in which you are enrolled. You must respond to this correspondence before the claim can be processed.
6. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Consolidated Health Plans, Inc. at www.chpstudent.com or call (800) 633-7867.

Any provision of this Plan, which on the effective date, is in conflict with the statues of the state in which the Plan is issued will be administered to conform to the requirements of the state statutes.

QUESTIONS? NEED MORE INFORMATION?

For general information on benefits, on enrollment/eligibility questions, ID cards or service issues, please contact:

Servicing Agent:
UNIVERSITY HEALTH PLANS, INC.
One Batterymarch Park
Quincy, MA 02169-7454
Telephone (800) 437-6448
www.universityhealthplans.com
or email us at info@univhealthplans.com

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call University Health Plans to verify eligibility.

For information on University Policies regarding student health insurance, or for advice on claims processing, please contact:

Brown University Insurance Office
Box 1848
Providence, RI 02912
(401) 863-1703 or (401) 863-9481
www.brown.edu/insurance

CLAIM APPEAL

To appeal a claim, send a letter, within ninety (90) days of denial or partial denial, stating the issues of the appeal to Consolidated Health Plan's Appeal Department at the address below. Include your name, phone number, address, school attended and email address, if available. Claims will be reviewed and responded to within sixty (60) days by Consolidated Health Plans.

Translation services are available to assist insured's, upon request, related to administrative services.

For information on a specific claim or to check the status of a claim, please contact:

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Ave
Springfield, MA 01104
(413) 733-4540
Toll Free (800) 633-7867
www.chpstudent.com
or email us at customerservice@consolidatedhealthplan.com
Group Number: S210207

To determine if a provider participates in First Health, students can call (800) 226-5116 or visit www.firsthealth.com

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

For information on the prescription drug program or to check on the status of a prescription drug claim, please contact:
Express Scripts: Call (800) 451-6245 or log onto www.express-scripts.com

This plan is underwritten by:
Nationwide Life Insurance Company
Policy Number: 302-120-3812