STUDENT HEALTH INSURANCE PLAN

For Students Of

Bryant UNIVERSITY

2014-2015

Underwritten by:
Companion Life Insurance Company
Columbia, SC
Policy Number: 2014I5A66

THIS BROCHURE OUTLINES THE INSURED'S COVERAGE AND SHOULD BE RETAINED

14-I5A66 (Bro.)

BRYANT UNIVERSITY

Dear Student:

Bryant University provides access to a Student Health Insurance Plan. At the beginning of each year you are given the opportunity to enroll or waive this student insurance plan. Before you waive coverage, check your current coverage carefully as frequently students arrive on campus without adequate coverage, especially if covered by a Health Maintenance Organization (HMO) or a managed care plan that has limited or no benefits in the Smithfield, RI area. Make sure you are fully covered while on campus and throughout the policy year for inpatient and outpatient hospitalization, diagnostic testing and x-ray services, prescription drugs, and mental health services. Also be aware of any deductibles required by your current plan.

STUDENT HEALTH INSURANCE PLAN

This is a brief description of the Student Health Insurance Plan available for the students of Bryant University. Companion Life Insurance Company underwrites this Plan. The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University during business hours. The Master Policy shall control in the event of any conflict between this Brochure and the Policy.

ELIGIBILITY

All full-time students at Bryant University are eligible to enroll in this Insurance Plan. All International Students and Athletes will be automatically enrolled in the health insurance but have the option to waive the insurance if they have proof of comparable coverage. Students must actively attend classes for at least the first thirty-one (31) days after the date for which coverage is purchased.

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.

ONLINE WAIVER PROCESS

The online Waiver process is the only accepted process for making your insurance selection. The deadline for processing the online waiver is **August 1, 2014** for students enrolling in the fall term and **February 1, 2015** for students newly enrolling in the spring term. Students who waive the Student Health Insurance Plan in the fall, waive coverage for the entire policy year. To document proof of comparable coverage, students need to complete the online waiver and submit it by the deadline date. To complete the online waiver, log on to the Bryant portal at https://my.bryant.edu, click on the Banner icon, choose Student Services and Financial Aid, then Health and Medical Forms and complete the "Health Insurance Information" form. If you waive the school health plan, you must provide Health Services with proof of your own health insurance by submitting a copy of the front and back of your insurance card.

ATHLETES/INTERNATIONAL STUDENT WAIVER PROCESS

All Athletes and International Students will automatically be enrolled and billed $1,708 for the Student Health Insurance Plan unless they waive the insurance plan and also provide proof of comparable coverage in another health insurance plan (preferably in the United States that will be in effect from August, 2014 through August, 2015). If you have your own health insurance that is

acceptable in RI, you must provide proof of the alternative insurance to Health Services by August 1, 2014 by logging into https://my.bryant.edu, click on the Medicat icon, then Required Forms, and then finally Insurance Entry. Please input your insurance information and click on the Insurance Waiver link to waive the student health insurance. Once you complete the health insurance information and submit it online, the charge will be removed from your Bryant student account if the alternative insurance is acceptable. If you are waiving the plan, please provide a copy of the front and back of your insurance card to Health Services as proof of health insurance.

Bryant University reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Health Insurance Plan, effective the date that the determination was made and there will be no pro-rata refund of premium.

QUALIFYING EVENT ENROLLMENT

In the event a student waives the Student Health Insurance Plan and then loses coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students have the right to petition to add coverage within thirty-one (31) days of the qualifying event. If the petition is received within thirty-one (31) days of the qualifying event, there will be no break in coverage. Petitions received after the thirty-one (31) days, the effective date of coverage will be the date that the petition is received by University Health Plans. If approved, the premium will not be prorated.

DEPENDENT ELIGIBILITY

Students enrolled in the Student Health Insurance Plan may enroll their eligible Dependents (as defined) at an additional cost.

"Dependent" means: 1) an Insured's lawful spouse or registered domestic partner or party to a civil union; or 2) an Insured's child under the age of twenty-six (26) and 3) an unmarried child of any age who is financially dependent upon the parents and medically determined to have a physical or mental impairment which can be expected to result in death or which as lasted or can be expected to last for a continuous period of not less than twelve (12) months.

A "child", includes an Insured's: 1) natural child; 2) stepchild; and 3) adopted child, beginning with any waiting period pending finalization of the child's adoption. The term "child" also includes the child of your domestic partner.

The term "spouse" also includes your domestic partner.

Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child, for dependent benefits from and after the moment of birth, or any child placed with the Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption.

To continue the dependent child's coverage past the first thirty-one (31) days, or to obtain any other dependent coverage, the Insured Student must complete and submit the Dependent Enrollment Form within thirty-one (31) days of the child's birth or date of placement for adoption or date of marriage.

DEPENDENT ENROLLMENT

There are two ways to submit dependent enrollment information. You may request a Dependent Enrollment form by contacting University Health Plans at 800-437-6448, or you may submit an Online Dependent Enrollment Form. To submit dependent information online, go to www.universityhealthplans.com.

Payment for dependent coverage is in addition to the fee for student coverage. New or previously insured Dependents must be enrolled by September 15, 2014 for annual coverage or February 25, 2015 for spring semester for new students to Bryant University. If the deadline for enrolling an eligible dependent is not met, the dependent cannot be added until the following school term. The deadline to add eligible dependents due to a qualifying event (i.e. birth, marriage, loss of coverage), is thirty-one (31) days from the qualifying event in order to avoid a break in continuous coverage. If the deadline is not met, the effective date will be the postmark date on the envelope or the date the online Dependent Enrollment form is submitted.

EFFECTIVE AND TERMINATION DATES

The Master Policy on file at the school becomes effective on August 15, 2014. Coverage becomes effective on that date or the date the enrollment form and premium are received by the Company, whichever is later. The Master Policy terminates on August 14, 2015. Coverage terminates on that date

or the end of the period for which premium is paid, whichever is earlier.

PLAN COSTS

	Annual 8/15/14-8/14/15	Spring Term 1/15/15-8/14/15
Student	$1,708	$1,029
Spouse	$4,039	$2,426
Child(ren)	$2,672	$1,481

The above rates include an administrative fee retained by the servicing agent.

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. 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, graduating students, and students electing to enroll in a separate comparable plan during the policy year. Premiums received by the Company are fully earned upon receipt and are non-refundable except as specifically provided. 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-rated refund of premium upon written request.

PREFERRED PROVIDER NETWORK

The Bryant 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 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" means a provider who has not agreed to any prearranged fee schedules. We will not pay charges in excess of the Usual & Customary (U&C) Charges.

Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are Insured's responsibility.

PRESCRIPTION DRUG BENEFIT

The Prescription Program is available through the Express Scripts Pharmacy Network. After a $10 co-payment for a 30-day supply of a generic drug, ($0 co-pay for a 30-day supply of a generic Contraceptive) and a $20 co-payment for a 30-day supply of a brand name drug. Insured Persons will be given an ID card to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving the ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained from Consolidated Health Plans.) To locate a participating Express Scripts Pharmacy, please call Consolidated Health Plans at (800) 633-7867 or visit Express Scripts website at www.express-scripts.com. Not all medications are covered, for example vitamins or food supplements, drugs to promote hair growth or weight loss, and experimental drugs are not covered.

DEFINITIONS

Accident means an unexpected and unintended event, which is the direct cause of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

Injury means accidental bodily harm sustained by a Covered Person that results directly and independently of disease and any bodily infirmity from a Covered Accident. All injuries sustained by one person in any one Accident, including all

related conditions and recurrent symptoms of these injuries are considered a single Injury.

Sickness means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

Insured means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

Doctor means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certification.

It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

Hospital means an institution that:

1. Operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons;
2. Provides twenty-four (24) hour nursing service by Registered Nurses on duty or call;
3. Has a staff of one (1) or more licensed Doctors available at all times;
4. Provides organized facilities for diagnosis, treatment and surgery either: a) on its premises; or b) in facilities available to it, on a prearranged basis; and
5. Is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such.

Hospital also means a licensed alcohol and drug abuse rehabilitation facility or a mental hospital. Alcohol and drug abuse rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

Emergency Hospitalization and/or Emergency Medical Care means Hospitalization or medical care that is provided for an Injury or Sickness caused by the unexpected onset of a medical condition with acute symptoms of sufficient severity and pain that would cause a prudent layperson with an average knowledge of health and medicine to expect that the absence of immediate medical care to result in:

1. The Covered Person's health or in the case of a pregnant woman, the health of the woman and her unborn child, being placed in serious jeopardy.
2. Serious impairment of the Covered Person's bodily functions.
3. Serious dysfunction of any of the Covered Person's bodily organs or parts.

Medically Necessary means a service, drug or supply which is necessary and appropriate for the diagnosis and treatment of a Covered Injury and Covered Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided. A service, drug or supply will not be considered as Medically Necessary if, it:

1. is investigational, experimental or for research purposes;
2. is provided solely for the convenience of the patient, the patient's family Doctor, Hospital or any other provider;

3. exceeds in scope, duration or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. could have been omitted without adversely affecting the person's condition or the quality of medical care; or
5. involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration.

Usual and Customary Charge means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

We, Us or Our means Companion Life Insurance Company, Inc., or its authorized agent.

STATE MANDATED BENEFITS

State mandated benefits will be subject to all deductible, co-payment, co-insurance, limitations, or any other provision of the Policy. If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

Ambulance Services Benefit: We will pay the expenses incurred for ambulance services as outlined in the Schedule of Benefits.

As used in this section the term Ground Ambulance Services shall mean 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.

Cytological Screening Expense: We will pay the expense incurred for cytological screening (Pap smear) in accordance with guidelines established by the American Cancer Society.

Diabetes Treatment Expense Benefit: We shall provide coverage to the Insured Person for equipment and supplies that are used in the treatment of insulin treated diabetes, non-insulin treated diabetes, and gestational diabetes. We will provide coverage for the following equipment and supplies if Medically Necessary and prescribed by a Doctor: a) blood glucose monitors for the legally blind; b) test strips for glucose monitors and or visual readings; c) insulin; d) injection aids; e) cartridges for the legally blind; f) syringes; g) insulin pumps and appurtenances; h) insulin infusion devices; i) oral agents for controlling blood sugar; and j) therapeutic/molded shoes for the prevention of amputation. We shall provide coverage, when Medically Necessary and prescribed by a Doctor for the following: 1) new or improved diabetes equipment and supplies, which have been approved by the Food and Drug Administration (FDA); 2) diabetes self-management education to ensure that the Insured Person is instructed in the self-management and treatment of their diabetes; 3) coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when Medically Necessary.

Early Intervention Services for Dependent Children: Covered services include, but are not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, 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. Benefits are limited to $5,000 per dependent child per Policy Year and are not subject to deductibles or coinsurance.

Non-prescription Enteral Nutrition Products Expense: Benefits will be paid up to $2,500 per Policy Year for non-prescription enteral nutritional products which are necessary when recommended by the attending Physician 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.

Hearing Aids: Benefits will be paid up to $1,500 per individual hearing aid, per ear, every three (3) years for an Insured Person under age nineteen (19). Coverage for $700 per individual hearing aid, per ear, every three (3) years for an Insured Person over age nineteen (19). 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.

Home Health Care Expense: The Company will pay the expenses incurred for Home Health Care Services according to a home health care plan that is formulated and supervised by the Insured Person's Physician for the treatment of a Covered Injury or Sickness. Home Health Care is a Medically Necessary program to reduce the length of a Hospital Stay or to delay or eliminate an otherwise necessary Hospital admission.

Covered services include the following services as needed: physical therapy, occupational therapy as a rehabilitative service, respiratory service, speech therapy, medical social work, nutrition counseling, the services of a home health aide, drugs and medications, medical and surgical supplies such as dressings, bandages and casts, minor medical equipment such as commodes and walkers,

laboratory testing, X-rays and E.E.G. and E.K.G. evaluations.

Benefits for Home Health Care services are payable only when the services are Medically Necessary and provided in conjunction with a Physician approved Home Health Care services plan.

Infertility Expense Benefit: We will provide coverage to the Insured Person for Medically Necessary expenses incurred for tests and procedures used in the diagnosis and treatment of Infertility. Infertility means the condition of an otherwise presumably healthy married individual 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. We will pay the Usual and Customary Expense incurred on the same basis as any other Sickness.

Leukocyte Testing Expense: The Company will pay the expenses incurred for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. The testing must be performed in a facility that is accredited by the American Association of Blood Banks or its successors and is licensed under the Clinical Laboratory Improvement Act. At the time of testing, the person being tested must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program. The Company will pay for one (1) such test per lifetime of an Insured Person.

Lyme Disease Treatment: Benefits will be paid for expense incurred for diagnostic testing and long-term antibiotic treatment of chronic lyme disease when such is determined to be Medically Necessary and ordered by a Physician who is acting in accordance with Chapter 37.5 of Title 5 entitled

Lyme Disease Diagnosis and Treatment, after making a thorough evaluation of the patient's symptoms, diagnostic test results and response to treatment. The Company will not deny benefits for such treatment that is otherwise payable because such treatment may be characterized as unproven, experimental or investigational in nature.

Mammography Expense (Payable as a Sickness Benefit Only): The Company will pay the expenses incurred for mammography charges. We will pay the expenses incurred for mammography charges in accordance with the guidelines established by the American Cancer Society. We shall pay for two (2) screening mammograms per year when recommended by a physician for women who have been treated for breast cancer within the last five (5) years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.

Mastectomy Surgery and Rehabilitation Benefit: The surgical procedure known as a mastectomy will be covered under the Surgery Benefit of this Section. Under this benefit, The Company will pay the expenses incurred for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the Insured Person following a covered mastectomy.

As used in this benefit, **prosthetic device** means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the Insured Person's Physician and surgeon.

Mastectomy Hospital Stay Expense: We shall provide coverage for a minimum forty-eight (48) hour time period in a hospital after the surgical procedures known as a mastectomy, and a minimum twenty-four (24) hours after an axillary node dissection.

New Cancer Therapies Expense: The Company will pay the expense incurred for new cancer therapies still under investigation under the following circumstances:

1. Treatment is provided pursuant to a Phase II, III or IV clinical trail that has been approved by the National Institute of Health in cooperation with the National Cancer Institute, community clinical oncology programs, the Food and Drug Administration in the form of an Investigational New Drug exemption, the Department of Veterans' Affairs, or a qualified non-governmental research entity as identified in the guidelines of the National Cancer Institute Cancer Center support grants;
2. The proposed therapy has been reviewed and approved by a qualified institutional review board;
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; The patients receiving the investigational treatment meet all protocol treatment; and
4. The available clinical or pre-clinical data provide a reasonable expectation that the protocol treatment will be at least as effective as the non-investigational alternative.

The Company will not pay for that portion of treatment that is provided as part of a Phase II clinical trial and is otherwise funded by a national agency, such as the National Cancer Institute, and the Veterans' Administration, the Department of Defense, or funded by commercial organizations such as bio-technical and/or pharmaceutical industry or manufactures of medical devices.

Off-Label Drug Treatments: When prescription drugs are provided as a benefit of the Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met: 1) The drug is approved by the FDA; 2) The drug is prescribed for the treatment of cancer and 3) The drug has been recognized for treatment of that condition by one of the following: a) The American Medical Association Drug Evaluations; b) The Dispensing Information, Volume 1, "Drug Information for Health Care Professionals"; or c) 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 a clear and convincing contradictory evidence presented in a major peer reviewed medical journal. When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit documentation supporting compliance with these requirements.

Coverage for Orthotic and Prosthetic Services: The benefits provided under this provision are the same as benefits provided under federal laws (42 U.S.C. sections 1395K, 13951 and 1395M and 42 CFR 414.202, 414.210, 414.228, and 410.100 as applicable to this section). Prior authorization may be required to receive this benefit if required for other benefits. Benefits are limited to the model that adequately meets the patient's medical needs as determined by the treating physician. Repair and replacement of an orthotic or prosthetic device is covered and subject to co-payments and deductibles, unless necessitated by misuse or loss.

Pediatric Preventive Care Expense Benefit: We will pay the Usual and Customary Expenses

incurred on the same basis as any other Sickness for services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a Doctor and rendered to a child from birth through age nineteen (19).

Postpartum Hospital Stay Expense: When Hospital confinement is as the result of pregnancy, The Company will pay the expenses incurred for a minimum of forty-eight (48) hours following a vaginal birth and ninety-six (96) hours following a Cesarean section for a mother and her newly born child. Any decisions to shorten these minimums will be made in accordance with the standard guidelines for perinatal care published by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics. In the case of any early discharge, post-delivery care will include home visits, parent education, assistance and training in breast and bottle-feeding and the performance of any Medically Necessary and appropriate clinical tests or other tests or services with the above guidelines.

Prostate and Colorectal Cancer Screening Expense (Payable as a Sickness Benefit Only): The Company will pay the expenses incurred for prostate and colorectal examinations and laboratory tests for cancer for any non-symptomatic person covered under this Policy, in accordance with American Cancer Society Guidelines.

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 not to exceed $350 per Insured Person per year, exclusive of any deductible.

Tobacco Cessation Treatment: We will pay the expenses incurred for Tobacco Cessation Treatments the same as any other Covered Sickness. Tobacco Cessation Treatments will include outpatient counseling for smoking cessation when provided by a qualified provider. If prescription drug coverage is provided under the Policy 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 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. Smoking cessation treatment may be redefined by the Health Insurance Commissioner in accordance with the most current clinical practice guidelines sponsored by the United States Department of Health and Human Services or its component agencies.

Pediatric Preventive Dental Care Benefit: This benefit only applies to Insured Persons under age 19. We will provide benefits for:

1. Preventive & diagnostic services limited to 2 exams/prophylaxis/ topical fluoride treatments per Policy Year including bitewing, full-mouth and panoramic x-rays (1 per 36 months); sealants as needed for 1st and 2nd molars only (1 per tooth every 36 months) and space maintainers.
2. Basic restorative services including emergency palliative treatment of pain; fillings (amalgam, resin-based composite); and simple extractions.

3. Major services including prosthodontics (crowns, bridges and dentures; 1 per tooth/arch every 60 months; endodontics (root canals on permanent teeth limited to one per tooth per lifetime); periodontics (scaling and root planning, limited to 1 every 24 months; gingivectomy, limited to 1 every 36 months); oral surgery; and general anesthesia in conjunction with complex oral surgery.
4. Medically necessary orthodontia services. **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.

Pediatric Vision Care Benefit: This benefit only applies to Insured Persons under age 19. We will provide benefits for: (1) one vision examination per Policy Year; and (2) one pair of prescription lenses and frames or contact lenses in lieu of eye glasses per Policy Year.

Mental Illness and Substance Abuse Expense Benefit:

Inpatient Expense: When an Insured Person requires Hospital Confinement for treatment of a mental illness or substance abuse, We will pay the Usual and Customary charges incurred for such Confinement on the same basis as for any other Covered Sickness.

Outpatient Expense: When the Insured Person does not require Hospital Confinement for the treatment of a Mental Illness or Substance Abuse, We will pay the Usual and Customary charges incurred on the same basis as for any other Covered Sickness, for Outpatient Mental Illness, Outpatient Services for Substance Abuse,

Community residential care services for substance abuse treatment and Detoxification.

Outpatient services must be furnished by:

1. A comprehensive health care services organization;
2. A Hospital;
3. A Facility approved by the State Department of Mental Health which is a community mental health center, or any other mental health clinic; or
4. An independent clinical social worker or clinical specialist in psychiatric and mental health nursing.

As it pertains to this benefit, **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 (ICO) published by the World Health Organization. Such disorder must substantially limit the life activities of the person with the illness. However, tobacco and caffeine are hereby excluded from the definition of "substance" for the purpose of this provision.

Mental Illness does not include:

1. Mental retardation;
2. Learning disorder;
3. Motor skills disorder;
4. Communication disorders; and
5. Mental disorders classified as "V" codes.

We will pay the above benefits provided that the providers of such treatment can substantiate that initial or continued treatment is at all times Medically Necessary and appropriate.

EXTENSION OF BENEFITS

If a Covered Person is confined in a Hospital for a medical condition on the date his insurance ends, expenses Incurred during the continuation of that Hospital stay will be considered a Covered Expense, but only while such expenses are incurred during the ninety (90) day period following the termination of insurance. We will not continue to pay these Covered Expenses if:

1. the Covered Person's medical condition no longer continues;
2. the Covered Person reaches the Aggregate Maximum;
3. the Covered Person obtains other coverage; or
4. the Covered Expenses are incurred more than three (3) months following termination of insurance.

COORDINATION OF BENEFITS PROVISION

Benefits will be coordinated with any other group medical, surgical, or hospital plan as described in the Coordination of Benefits provision of the Policy so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

CONTINUOUS COVERAGE

Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under the Policy when premium payment is received either in Our School Plans Service Office or by Our Agent or the Plan Administrator within thirty (30) days, regardless of any breaks in calendar days between consecutive periods of insurance.

EXCLUSIONS & LIMITATIONS

Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of that Act. The Plan does not cover nor provide coverage for loss caused by or resulting from:

1) Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of any Injury or Sickness, except as specifically provided by the Policy.
2) Immunizations, except as specifically provided in the Policy; preventive medicines or vaccines, except when required for treatment of a covered Injury or as specifically provided in the Policy.
3) War, or any act of war, whether declared or undeclared; service in the Armed Forces of any country. Loss which occurs during or as a result of committing or attempting to commit an assault, felony, or participation in a riot or insurrection, engaging in an illegal occupation.
4) Injuries arising out of playing or participating in any professional sport, contest or competition; traveling to or from such sport, contest or competition as a participant; or participation in any practice or conditioning program for such sport, contest or competition.
5) Expenses incurred for Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation.

6) Expenses in connection with services and prescriptions for eye examinations, eye refractions, eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems, except as specifically provided by the policy.
7) Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of: a) a covered Injury that occurred while the Covered Person was insured; b) a covered child's congenital defect or anomaly; or c) as specifically provided for in the Policy.
8) Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury or as provided in the Schedule of Benefits for Sickness Dental Expense or Pediatric Dental Services.
9) Elective Surgery or Elective Treatment as defined by the Policy.
10) Foot care including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, week feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care.
11) Injuries arising out of a) playing or participating in an interscholastic or intercollegiate sport, contest or competition; b) traveling to or from such sport, contest or competition as a participant; or c) participating in any practice or conditioning program for such sport, contest or competition; in excess of $100,000 per policy year.
12) Expenses incurred for Acupuncture.

RIGHT OF REIMBURSEMENT

If a Covered Person incurs expenses for Sickness or Injury that occurred due to the negligence of a third party: (a) We have the right to reimbursement for all benefits We have paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement or compromise by the Covered person, Covered Person's parents, it the Covered Person is a minor, or Covered Person's legal representative as a result of that Sickness or Injury, and (b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid for that Sickness or Injury. We shall have the right to reimbursement out of all funds that the Covered Person, the Covered person's parents, if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to obtain for the same expense we have paid as a result of that Sickness or Injury.

The Covered Person or the Covered Person's parents if the Covered Person is a minor is required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether the third party admits liability or not.

CLAIM PROCEDURES

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

1. Report to the nearest Doctor or Hospital and follow the prescribed treatment advice.
2. A claim form is not required to submit a claim. However, an itemized bill, (HCFA 1500, or UB04) should be used to submit expenses. The Insured Student/Person's name and identification number needs to be included. Providers should submit claims within ninety (90) days from the date of Accident or from the date of first medical treatment for a Sickness, or as soon as reasonably possible. If a student is submitting a claim, a copy should be retained and claims should be mailed to the Claims Administrator.
3. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to the Claims Administrator, Consolidated Health Plans.

HOW TO FILE AN APPEAL

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person must request an appeal in writing within one hundred eighty (180) days of the date appearing on the EOB. The appeal request must include why the Insured Person disagrees with the way the claim was processed. The request must include any additional information he/she feels supports the request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator, Consolidated Health Plans.

The Plan is Underwritten By:
Companion Life Insurance Company
Columbia, SC
As Policy Form BSHP-POL-RI et al
Policy Number: 2014I5A66

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

Servicing Broker:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
800-437-6448
Email: www.universityhealthplans.com

For a copy of the Company's privacy notice you may go to:
www.commercialtravelers.com/privacy.html
Or
Request one from the Health Office at your School
Or
Request one from:
Commercial Travelers Mutual Insurance Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502

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

Representations of this plan must be approved by the Company.

VALUE ADDED SERVICES

The following services are not part of the Indemnity Plan Underwritten by Companion Life Insurance Company. These value added options are provided by Consolidated Health Plans in partnership with Davis Vision and FrontierMEDEX.

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.

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:
www.chpstudent.com