STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

For Students Of

2015-2016

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

Underwritten by:
Companion Life Insurance Company
Columbia, SC
Policy Number: 2015I5A06

Group Number: S201897

15-I5A51 (Cert.)

SALVE REGINA UNIVERSITY

Dear Student:
Occasionally, unexpected Injury and Sickness place serious financial strain on some Salve Regina students and families. In response to this concern, the University sponsors a Student Accident and Sickness Insurance Plan designed specifically to protect students against rising medical costs. Because medical insurance is so important, it is required that all full-time students enroll in the Plan.

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Student Accident and Sickness Insurance Plan available for the students of Salve Regina 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 undergraduate full-time students and part-time resident students of Salve Regina University are automatically enrolled in the Student Accident and Sickness Insurance Plan, unless proof of comparable coverage is provided.

ONLINE WAIVER PROCESS

If You are eligible to be covered under this Program, You are automatically enrolled, unless You waive coverage. Students who do not want to enroll in the Student Accident and Sickness Insurance Plan can waive coverage if they can document proof of comparable coverage in another health insurance plan that will be in effect from 12:01 a.m. on August 15, 2015 through 12:01 a.m. on August 15, 2016. Recognizing that health insurance situations may change, each year students will be asked to provide proof of comparable coverage in order to waive participation in the Student Accident and Sickness Insurance Plan. To document proof of comparable coverage, students need to complete the online Waiver Form and submit it by the deadline. Go to www.universityhealthplans.com to submit the online Waiver Form.

The online Waiver process is the only accepted process for making your insurance selection. The deadline for processing the online waiver is **August 1, 2015** for students enrolling in the fall and **January 15, 2016** for students newly enrolling in the spring term. **Students who do not submit the online Waiver Form by the deadline will be automatically enrolled in the Student Accident and Sickness Insurance Plan and the fee will remain on their student account bill.**

TERM OF COVERAGE

The insurance under Salve Regina University Student Accident and Sickness Insurance Plan for the Annual Policy is effective 12:01 a.m. on August 15, 2015. An eligible student's coverage becomes effective on that date or the date the application and full premium are received by Salve Regina University, whichever is later. The Annual Policy terminates at 12:01 a.m. on August 15, 2016 or at the end of the period through which the premiums are paid. Coverage for new students enrolling in the second semester begins on January 15, 2016 and ends on August 15, 2016.

PLAN COSTS

	Annual 8/15/15-8/15/16	Fall 8/15/15-1/15/16	Spring 1/15/16-8/15/16
Student	$2,239	$953	$1,316

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

PREMIUM REFUND POLICY

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 within ninety (90) days of withdrawal from the University.

Premiums received by the Company are fully earned upon receipt.

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.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which:

1. causes a loss while the Policy is in force; and
2. which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorders and Substance Abuse Disorders.

Doctor means a Doctor who is 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 certificate.

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

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.

Essential Health Benefits means benefits that are defined as such by the Secretary of Labor in the following general categories, and the items and services covered within the categories:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental Health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Hospital means an institution that:

1. Operates as a Hospital pursuant to law for 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;
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.

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.

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.

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.

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 (1) Sickness.

Substance Abuse means abuse of or addiction to drugs or alcohol.

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.

BASIC ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

If as the result of any covered condition, an Insured Person incurs medical expenses, We will pay 100% of the Usual and Customary Expense incurred, as allocated below, up to a maximum of $5,000 after a $100 policy year deductible applicable to inpatient benefits only.

INPATIENT BENEFITS

After a $100 inpatient services policy year deductible, We will pay the following:

Hospital Room and Board Expense: If an Insured Person requires confinement in a Hospital, We will pay the Usual and Customary Expense incurred up to the semi-private rate or the Intensive Care Unit rate.

Hospital Miscellaneous Expense: If an Insured Person incurs expenses during a Hospital confinement for: anesthesia; operating room; laboratory tests; x-rays; oxygen tent; drugs; medicines; dressings; and other medically necessary non-room and board expenses, We will pay the Usual and Customary Expense incurred.

In Hospital Doctor's Visits Expense: If an Insured Person requires the services of a Physician, other than the surgeon, while confined to a Hospital, We will pay the Usual and Customary Expense incurred.

Surgical Expense (Inpatient or Outpatient): We will pay the Usual and Customary Expense incurred up to a maximum of $5,000 for surgery performed by a licensed Physician for both pre- and post-operative care.

Anesthetist Expense: If an Insured Person requires an anesthetist during a surgical operation, We will pay the Usual and Customary Expense.

Assistant Surgeon Expense: If an Insured Person requires an assistant surgeon during a surgical operation, We will pay the Usual and Customary Expense.

Inpatient Mental Illness and Substance Abuse Expense Benefit: If an Insured Person requires treatment for mental and nervous disorders during Hospital confinement, We will pay for the Usual and Customary Expense incurred as any other Sickness.

Inpatient Registered Nurse Service, We will pay the Usual and Customary Expense incurred when private duty nursing care is prescribed by the attending Doctor. General nursing care provided by the Hospital is not covered under this benefit.

Inpatient Physical Rehabilitation – We will pay the Usual and Customary Expense incurred for inpatient physical rehabilitation when prescribed by the attending Doctor.

OUTPATIENT BENEFITS

IMPORTANT NOTE: Outpatient benefits in the Newport area are only payable with prior approval from the University Health Services. If the on-campus University Health Service is closed or not accessible due to a Medical Emergency, students should go to the Newport Hospital.

Outpatient Expense: If, by reason of any covered condition, an Insured Person incurs expenses in a Physician's office, Hospital outpatient department, ambulatory surgery center, emergency room, urgent care center, clinical lab, radiological facility, or other similar facility licensed by the state, the Company will pay the Usual and Customary Expense incurred, (eighty percent (80%) of the Usual and Customary Expense incurred when services are received at other providers during school break or vacation periods without approval from University Health Services), subject to the following co-payments. Students should receive services at the University Health Services first. Outpatient Expense will include coverage for one annual physical (with no co-pay).

This benefit will include visits for Primary Care, Specialists, Chiropractic Care and other Licensed Practitioners. This benefit will also include one routine Adult Eye exam per Policy Year.

Co-payments:

1. $20 co-payment per visit, if treated in a Physician's office.
2. $20 co-payment per visit, for all outpatient Newport Hospital visits.
3. $100 co-payment per visit, if treated at a non-Newport Hospital emergency room, Urgent Care Center or for a Non-Newport Hospital Outpatient Department visit.

NOTE: The Newport Hospital co-payment will be waived in the following situations:

1. The Newport Hospital Emergency Room co-payment will be waived in the case of a medical emergency, requiring Emergency Medical Care as defined.
2. The Newport Hospital outpatient co-payment will be waived for diagnostic work ordered by University Health Services.

Consultant Expense: If an Insured Person requires the service of a consultant when they are deemed necessary and ordered by an attending physician or University Health Services for the purpose of confirming or determining a diagnosis, We will pay the Usual and Customary Expense incurred. Additional treatments will be covered under the Outpatient Expense.

Ambulance Expense: If an Insured Person requires the use of a professional ground ambulance for a Medical Emergency, We will pay the Usual and Customary Expense incurred for travel to and from the local Hospital.

Sickness Dental Expense: If an Insured Person requires the services of a Physician for the treatment or extraction of an unerupted or impacted wisdom tooth, We will pay the Usual and Customary Expense incurred up to $125 per tooth.

Accidental Dental Expense: We will pay the Usual and Customary Expenses for dental treatment as a result of Accidental Injury to sound natural teeth up to a maximum of $250 per Injury.

Outpatient Rehabilitation and Habilitation Services: When prescribed by the attending Doctor, we will pay the Usual and Customary Expense for benefits for outpatient physical therapy, occupational therapy, speech therapy, and cardiac rehabilitation, for Medically Necessary treatment of a Covered Injury or Covered Sickness.

Preventive Care, Screening and Immunizations: We will pay the Usual and Customary expenses incurred for preventive care, screening and immunization services (including STD testing). No co-pay, coinsurance or deductible will apply.

Braces and Appliances: We will pay the Usual and Customary Expense incurred when prescribed by a Doctor and a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable medical equipment which is equipment that is primarily used to serve a medical purpose, can withstand repeated use, and generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.

Skilled Nursing Facility Benefit: We will pay for Usual and Customary Expense incurred for services received in a licensed Skilled Nursing Facility up to a maximum of 120 days per Policy Year. Services must be Medically Necessary. Confinement for custodial care or residential care is not covered.

For the purpose of this benefit, Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which:

1. Mainly provides inpatient care and treatment for persons who are recovering from an illness or injury;
2. Provides care supervised by a Physician.

3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency;
5. Is not a rest, educational, or custodial facility or similar place.

Hospice Care: We will pay the Usual and Customary Expense incurred for Hospice Care provided by a licensed agency or provider for terminally ill patients with a life expectancy of 6 months or less.

PRESCRIPTION DRUG BENEFIT

The Prescription Program is available through the Catamaran Pharmacy Network. After a $10 co-payment for a 30-day supply of a generic drug (no cost for generic prescription contraceptives) and a $20 co-payment for a 30-day supply of a brand name drug, a prescription will be paid at U&C. Insured Persons will be given an ID 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 Catamaran Pharmacy, please call Consolidated Health Plans at 1-800-633-7867. Not all medications are covered, for example vitamins or food supplements, drugs to promote hair growth or weight loss, immunizations, and experimental drugs.

INTERCOLLEGIATE SPORTS EXPENSE

Injuries as a result of practice or play of Intercollegiate Sports will be paid at the Usual and Customary Expense incurred up to $1,500 per Injury per Policy Year under a separate Policy.

SUPPLEMENTAL ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

If an Insured Person satisfies the Basic Accident and Sickness Benefits of $5,000, We will pay for 80% of the Usual and Customary Expense incurred in excess of $5,000. Hospital Room and Board Expenses are limited to the Usual and Customary Expense of a semi-private room rate. Benefits under the Supplemental Accident and Sickness Medical Expense Benefits will be payable for Usual and Customary Expenses incurred for an Injury or Sickness.

This plan has a $6,350 Out-of-Pocket Maximum. The Out-of-Pocket Maximum is the most You pay during a Policy Year before Your Coverage begins to pay 100%. This limit will never include Premium, balance-billed charges or health care Your Policy does not cover. Your Copayments (medical and prescriptions), Deductibles, and coinsurance will be used to satisfy the out-of-pocket maximum.

COVERAGE OUTSIDE OF THE UNITED STATES

Coverage under the Policy will include non-emergency care when traveling outside the United States. Benefits will be subject to all deductible, co-payment, co-insurance, limitations, or any other provision of the Policy.

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. The co-payment and/or deductible for Ground Ambulance Service only will not exceed $50. 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 and Insured Person over age nineteen (19). Hearing aid means any nonexperimental, 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 Doctor for the treatment of any covered condition. 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 to a maximum of 40 visits per Policy Year.

Infertility Expense Benefit: We shall 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, BLF, 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 axilary 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 trial 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;
4. The patients receiving the investigational treatment meet all protocol treatment; and

5. 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 dug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions has 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 Expense 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 nonsymptomatic 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 excess $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 nineteen (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 nineteen (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.

EMERGENCY MEDICAL EVACUATION

When as a result of a Covered Accident or Sickness, You are hospitalized for five (5) days or more, We will pay, upon the recommendation and approval of the attending Physician, for Your evacuation to Your natural country, or to a facility operated pursuant to the law for the care and treatment of injured or ill persons, the actual U&C

expense incurred, but not to exceed $50,000 in the aggregate. This benefit is payable in addition to any other benefit of this policy. Emergency Medical Evacuation must be approved in advance by the Company. See Policy for full benefit description.

REPATRIATION OF REMAINS COVERAGE

If You die while insured under this policy, We will pay the actual U&C expenses incurred for preparation, including cremation and transportation to Your home country (in accordance with the applicable international requirements) the remains of the deceased's body, but not to exceed $50,000 in the aggregate. This benefit is payable in addition to any other benefit of this policy. Repatriation of Remains must be approved in advance by the Company.

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 for any covered condition;
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

All benefits above $225 per Accident provided under this Plan are will be coordinated with any other valid and collectible insurance that is in force to an Insured Person and are subject to the conditions and limitations of this Plan. Sickness Expense Benefits are paid on a primary basis.

EXCLUSIONS & LIMITATIONS

Any Exclusion in conflict with the Patient Protection and Affordable Care Act or Mandated Benefits will be revised to comply and provide coverage as specifically stated in the Policy. Any Exclusion in direct conflict will be deleted in its entirety. The Plan does not provide coverage for loss caused by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Usual and Customary charge.
2. 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 for in the Policy.
3. Skeletal irregularities of one or both jaws including Temporomandibular Joint Dysfunction (TMJ); orthognathia and mandibular retrognathia; nasal or sinus surgery.
4. 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.

5. Injuries arising out of playing or participating in an intercollegiate 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 (intercollegiate sports will be covered under a separate Policy up to $1,500).
6. War, or any act of war, whether declared or undeclared; service in the Armed Forces of any country.
7. 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.
8. 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.
9. Treatment, services, supplies in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment.
10. 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, and specifically provided in the hospitalization and Anesthesia for Dental Procedures expense benefit or Pediatric Dental Care, except as specifically provided by the Policy.
11. Elective Surgery or Elective Treatment (including termination of pregnancy) as defined by the Policy.
12. 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.
13. Routine physical examination 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.
14. 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.
15. Expenses incurred for Acupuncture.

CLAIM PROCEDURES

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

1. If at Salve Regina University, report immediately to the University Health Services so that proper treatment can be prescribed or referral can be made and a claim form can be obtained; or Notify the Claims Administrator, Consolidated Health Plans, within thirty (30) days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible.
2. Complete the claim form in full, and sign it. If a student receives outpatient services at Newport Hospital, a claim form is not required. When an Insured Person uses a non-Newport Hospital provider, the Insured Person should obtain a claim form from the University Health Services or contact Consolidated Health Plans.
3. The completed claim form 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.
4. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills should be mailed promptly to the Claims Administrator at the address below. No additional claim forms are needed as long as the Insured Person's/Student's name and identification number are included on the bill.
5. 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.

CONFORMITY WITH STATE STATUTES

Any provision of this Plan, which on its effective date, is in conflict with the statutes of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

UNIVERSITY HEALTH SERVICES HOURS

Monday through Friday
8:00 A.M. to 5:00 P.M.
Extension #2904

The Plan is Underwritten By:
Companion Life Insurance Company
Columbia, SC
As Policy Form BSHP-POL-RI et al
Policy Number: 2015I5A06

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800-633-7867
www.chpstudent.com
Group Number: S210897

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

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