

# Student Health Insurance Plan

Designed for the Students  
of



**2016-2017**

**COMPANION LIFE INSURANCE**  
Columbia, South Carolina

**Policy Number: 2016I5A90**  
**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.

Administered by:



**Consolidated Health Plans**  
2077 Roosevelt Ave.  
Springfield, MA 01104

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## **PRIVACY POLICY**

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Consolidated Health Plans know that your privacy is important to you and we strive to protect the confidentiality 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](http://www.chpstudent.com).

## **INTRODUCTION**

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### **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 health care providers in the Brown University area and provides comprehensive coverage, extending beyond emergency care to include hospitalization (including room and board, physicians' fees, and 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 Companion Life Insurance Company and is serviced by University Health Plans. Claims are processed by Consolidated Health Plans.

### **STUDENT ELIGIBILITY AND ENROLLMENT**

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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**

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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 14, 2017.

Students will need to complete and submit an online Waiver. To access the Waiver, log on to [www.universityhealthplans.com](http://www.universityhealthplans.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**

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The deadline for ALL students to complete and submit the Waiver for annual coverage is June 1, 2016. For students who are newly enrolled students for second semester coverage, the waiver deadline is January 1, 2017. 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**

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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**

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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 14, 2016.

#### **DEPENDENT ELIGIBILITY AND ENROLLMENT**

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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.universityhealthplans.com](http://www.universityhealthplans.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.universityhealthplans.com](http://www.universityhealthplans.com) to enroll their eligible Dependents online. Eligible Dependents need to be added by September 15, 2016 for an effective date of August 15, 2016 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, 2017 for an effective date of January 15, 2017 and students who are newly enrolled at Brown for the Summer Semester must enroll their eligible dependents by July 1, 2017 for an effective date of June 1, 2017.

#### **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**

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The insurance under Brown University's Student Health Insurance Plan for the Annual Policy is effective 12:01 a.m. on August 15, 2016. 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, 2017 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, 2017 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, 2017.

The insurance for Summer Coverage is effective on 12:01 a.m. on June 1, 2017 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, 2017.

	<b>Annual Cost*</b> <b>8/15/16-8/15/17</b>	<b>Spring Cost*</b> <b>1/15/17-8/15/17</b>	<b>Summer Cost*</b> <b>6/1/17-8/15/17</b>
<b>Student</b>	\$3,548	\$2,068	\$742
<b>One Dependent</b>	\$3,503	\$2,035	\$720
<b>Two or More Dependents</b>	\$7,006	\$4,070	\$1,440

	<b>Annual Cost*</b> <b>8/1/16-8/15/17</b>
<b>1<sup>st</sup> Year Medical Student</b>	\$3,680

\*Rates above include an administrative fee.

#### **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.

A pro-rata refund of premium will be made only in the event:

1. the Covered Person enters full-time active duty in any Armed Forces; and
2. We receive proof of such active duty service.

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**

**HEALTH SERVICES, Andrews House, 13 Brown Street**

For Medical Care: Call (401) 863-3953 Patients are seen by appointment only; same day appointments available.

#### **Academic Year Hours**

Monday – Thursday: 8:30am to 7:00pm

Friday: 8:30am to 5:00pm

Saturday and Sunday: 9:00am to 4:00pm

#### **Winter / Spring Break / Summer Hours**

Monday – Friday: 8:30am to 5:00pm (8:00am to 4:00pm in the summer)

Closed Weekends, Thanksgiving Break and Winter Break (December 23rd -January 2<sup>nd</sup>)

**Emergency Care:** Call (401) 863-4111

Emergency care is available 24 hours/7 days per week. Call the Department of Public Safety at 401-863-4111 for Brown Emergency Medical Services (EMS).

#### **Health Services provides the following services:**

- Primary care of medical problems
- Routine medical care
- 24/7 nursing advice; Call 401-863-1330
- Health Promotion Department
- 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 Promotion and Brown EMS hours of operation and services are subject to change. Please refer to the Health Services website at [www.brown.edu/health](http://www.brown.edu/health) for the most current information. Please note this Plan will only pay for those expenses which are eligible. Not all services rendered by Health Services are considered eligible expenses under this Plan.

#### **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 Department of Public Safety at 863-4111.

## COUNSELING AND PSYCHOLOGICAL SERVICES, J Walter Wilson, Room 516

**To make an appointment:** call (401) 863-3476 during regular office hours.

### Academic Year Hours (September – May)

Monday – Friday 8:30am to 5:00pm for routine and urgent appointments.

Closed Nights, Weekends, and Holidays. Call (401) 863-3476 to reach an on-call clinician.

### Winter / Spring Break / Summer Hours

Monday – Friday: 8:30am to 5:00pm (8:00am to 4:00pm in the summer)

Closed Nights, Weekends, Holidays, Thanksgiving Break and Winter Break (December 23rd -January 2<sup>nd</sup>). Call (401) 863-3476 to reach an on-call clinician.

### Counseling and Psychological Services provides the following services:

- Short-term Psychotherapy (7 session limit/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 and assessment
- Crisis response for students who have been sexually assaulted
- Support groups
- Consultation regarding students of concern

Please note this Plan will only pay for those expenses which are eligible. Not all services rendered by Counseling and Psychological Services are considered eligible expenses under this Plan.

## STUDENT HEALTH INSURANCE BENEFITS

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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 Expense at the Preferred Provider level of benefits. If a Covered 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 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

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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 Insureds use Preferred Providers, out-of-pocket expenses will be less because any applicable coinsurance will be based on a Preferred Allowance.

The Insured 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. Insureds should always confirm when making an appointment that the provider participates in a Preferred Provider Network. By enrolling in this Insurance Program, you have the Cigna PPO Network of Participating Providers, providing access to quality health care at discounted fees. To find a complete listing of Cigna PPO Network of Participating Providers, go to [www.cigna.com](http://www.cigna.com), or contact Consolidated Health Plans at (413) 733-4540, toll-free at (800) 633-7867, or [www.chpstudent.com](http://www.chpstudent.com) for assistance.

If your current provider does not participate in the Cigna PPO Network you may continue to use the First Health Network but all claims must be submitted to Cigna first. You can find a provider at [www.firsthealth.com](http://www.firsthealth.com).

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

If care is received within the Network from a Preferred Provider, all Covered Expenses will be paid at the Preferred Provider level of benefits found on the Schedule of Benefits.

If a Preferred Provider is not available in the Network Area, or an Insured is out of the Country, benefits will be paid at the level of benefits shown on the Schedule of Benefits as a Preferred Provider.

**"Preferred Allowance"** means the amount a Preferred Provider will accept as payment in full for Covered Expenses.

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

**"Accident"** means a, 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 Expenses"** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date the Accident or Sickness occurs until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

**"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 Use Disorders.

**"Dependent"** means: 1) an Insured's lawful spouse or registered domestic partner or party to a civil union, including same sex partners; 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.

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

**"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 Insurer to be research, investigative, or experimental;
2. are not generally recognized and accepted medical practices in the United States.

**"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 an of the Covered Person's bodily organs or parts.

**"Essential Health Benefits"** mean benefits that are defined as such by the Secretary of Labor in the following 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. Preventative 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 the care, treatment, and providing of in-patient services for sick or injured persons;
2. provides 24-hour nursing service by Registered Nurses on duty or call;
3. has a staff of one 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 pre-arranged 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.

**"Preventive Care"** provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations. Well Baby and Child Care, and Well Adult Care benefits will be considered based on the following:

a) Evidence-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 that those issued is or around November 2009;

See <http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.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.

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

**ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS**

*Unless otherwise specified, any Deductibles, Co-payments, Co-insurance Percentages and Benefit Maximums apply on a per Covered Person*

<b>BROWN UNIVERSITY SCHEDULE OF BENEFITS</b>	
<p>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:</p>	
<b>Maximum Benefit</b>	<b>Unlimited</b>
<b>Policy Year Deductible</b>	<p><b>\$300</b> (per Insured Person)                      This Deductible does not apply to the following benefits:</p> <ul style="list-style-type: none"> <li>• Emergency Room Visits</li> <li>• Diagnostic X-Rays and Laboratory Tests, when ordered by University Health Services</li> <li>• Outpatient Mental Health Visits</li> <li>• Outpatient Physician Office Visits</li> <li>• Outpatient Prescription Drugs</li> <li>• Other Outpatient Services when provided by University Health Services</li> </ul>
	<p>\$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).</p>

<b>Out of Pocket Maximum</b>	<p><b>\$6,350 per Individual</b>  <b>\$12,700 per Family</b></p>	
<b>Covered Inpatient Expenses:</b>		
<ul style="list-style-type: none"> <li>• Includes Copayments; Deductibles &amp; Prescription Drug Copayments;</li> <li>• Excludes non-covered medical expenses &amp; Elective services;</li> <li>• Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year;</li> <li>• Once the Out-of-Pocket Limit is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100%.</li> </ul>		
Hospital Room & Board – Limited to the semiprivate room rate. - Subject to a \$100 Per Policy Year Deductible	100% of Preferred Allowance (PA)	70% Usual and Customary Charges (U&C)
Hospital Miscellaneous	100% of PA	70% U&C
Intensive Care	100% of PA	70% U&C
Surgery	100% of PA	70% U&C
Anesthetist & Assistant Surgeon Fees	100% of PA	70% U&C
Doctor’s Visit – limited to 1 per day and does not apply when related to surgery	100% of PA	70% U&C
Emergency Room Care (deductible waived)	\$100 copay per visit, then 100% of PA (copay waived if admitted)	\$100 copay per visit, then 100% of PA (copay waived if admitted)
Urgent Care Center	\$25 copay per visit, then 100% of PA	\$25 copay per visit, then 70% U&C
Inpatient Physical Rehabilitation	100% of PA	70% U&C
Registered Nurse Service	80% of PA	70% U&C
Skilled Nursing Facility	100% of PA	70% U&C



<b>Covered Outpatient Expenses:</b>	<b>PPO Provider</b>	<b>Out-of-Network Provider</b>
Doctor's Visits – Does not apply when related to surgery or Outpatient Rehabilitation Services. Includes Primary Care, Specialist, and Other Licensed Practitioners. Includes one routine adult eye exam per Policy Year. (deductible waived)	\$15 copay per visit, then 100% of PA	\$15 copay per visit, then 70% U&C
Chiropractic Care, up to 12 treatments per Policy Year. (Massage Therapy is excluded unless provided by MD).	\$10 copay per visit, then 100% of PA	\$10 copay per visit, then 70% U&C
Day Surgery including day surgery miscellaneous expenses including Outpatient Facility and Ambulatory Surgery Center Fees - Subject to a \$100 Per Policy Year Deductible	100% of PA	70% U&C
Anesthetist & Assistant Surgeon Fees	100% of PA	70% U&C
Outpatient Rehabilitation and Habilitation Services including Physical, Occupational, Speech Therapy and Cardiac Rehabilitation Therapy	100% of PA	70% U&C
Outpatient Expense	100% of PA	70% U&C
Diagnostic X-ray and Laboratory Procedures (deductible waived when ordered by UHS)	100% of PA	70% U&C
Prescription Drugs – should be filled at an Express Scripts participating pharmacy. Deductible does not apply. Copays apply to a 30 day fill or refill. (deductible waived) Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> for participating pharmacies	100% of PA with \$0 copay for contraceptives; \$15 copay for generic drugs; \$30 copay for preferred brand name drugs; or \$50 copay 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 Scripts preferred brand pricing.

Hospice – by a licensed agency/provider for terminally ill patients with life expectancy of 6 months or less.	100% of PA	70% U&C
Home Health Care	100% of PA	70% U&C
<b>Other Covered Expenses:</b>	<b>PPO Provider</b>	<b>Out-of-Network Provider</b>
Durable Medical Equipment	80% U&C	70% U&C
Prosthetic Appliances and Orthotic Devices	100% of PA	70% U&C
Ambulance Service	80% U&C	70% U&C
Consulting Doctor Fees – When requested and approved by the attending Doctor.	Paid same as Physician Visits	
Maternity (including Birthing Center services and routine newborn care)	Payable as any other Sickness	
Complications of Pregnancy	Payable as any other Sickness	
Elective Abortion	Payable as any other Sickness	
Preventive Care, Screening and Immunizations	100% of PA (deductible does not apply)	70% U&C
Mental Illness and Substance Abuse	Paid as any other covered Sickness	
Dental Treatment (Injury Only to Sound, Natural Teeth)	80% U&C	70% U&C
Non-Emergency Treatment outside of the United States	100% of PA	
Sexual Reassignment Surgery/Gender Identity Disorder	Payable as any other Sickness	
Obesity (Bariatric) Surgery	Payable as any other Sickness	
Organ Transplant	Payable as any other Sickness	
Medical Evacuation	100% U&C	
Repatriation	100% U&C	
<b>Pediatric Dental</b>		
Preventive and Diagnostic	100% of U&C for Preventive	
Basic Restorative	70% of U&C	
Major Services	50% of U&C	
Medically Necessary Orthodontic (pre-authorization required)	50% of U&C	

<b>Covered Outpatient Expenses:</b>	<b>PPO Provider</b>	<b>Out-of-Network Provider</b>
Pediatric Vision Care Benefit, applies to Insureds under age 19		
- One (1) vision examination per Policy Year	100% of PA	\$15 copay per office visit, then 100% of U&C
- one set of frames/lenses	100% U&C	
<b>State Mandated Accident and Sickness Medical Expense Benefits:</b>		
	<b>PPO Provider</b>	<b>Out-of-Network Provider</b>
Autism Spectrum Disorders – up to the limits stated in the benefit description	100% of PA	70% U&C
Cancer Screening Tests <ul style="list-style-type: none"> <li>• Screening mammogram, two (2) screening mammograms per year when recommended by a Physician.</li> <li>• Annual Gynecological examination, including pelvic and breast examinations.</li> <li>• Cytological Screening.</li> <li>• Colorectal Cancer Screening.</li> <li>• Prostate Cancer Screening.</li> </ul>	100% of PA (deductible does not apply)	70% U&C
Contraceptive Coverage	\$0.00 Copay for Contraceptives	
Diabetes Equipment and Services	100% of PA	70% U&C
Early Intervention Services	100% of PA	70% U&C
Hair Prosthesis, - Limit one (1) per Policy Year	100% of PA	70% U&C
Hearing Aid	100% of PA	70% U&C
Infertility	100% of PA	70% U&C
Lead Poisoning	100% of PA	70% U&C
Leukocyte Testing	100% of PA	70% U&C
Lyme Disease Treatment	100% of PA	70% U&C
Mastectomy Expense – Mastectomy Surgery and Rehabilitation including Inpatient Care and Home Visits; Prosthetic Devices, Reconstructive Surgery	100% of PA	70% U&C

New Cancer Therapies	100% of PA	70% U&C
Non-Prescription Enteral Nutrition Products	100% of PA	70% U&C
Pediatric Preventive Care	100% of PA (Deductible does not apply)	70% U&C
Tobacco Cessation Treatment	100% of PA	70% U&C
Off-label Prescription Drugs	100% of PA	70% U&C

### **ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS**

We will pay the Covered Expenses as shown in the Schedule of Benefits if a Covered Person requires treatment by a Doctor. We will consider the Usual and Customary Charges incurred for Medically Necessary Covered Expenses. Benefit payments are subject to the deductibles, co-insurance factors and benefit maximums, if any, shown in the Schedule of Benefits.

#### **Covered Expenses include:**

##### **Inpatient Expenses**

1. Hospital Room and Board Expenses: daily semi-private room rate when Hospital Confined as shown in the Schedule of Benefits; and general nursing care provided and charged for by the Hospital.
2. Intensive Care as shown in the Schedule of Benefits. We will make this payment in lieu of the semi-private room expenses.
3. Hospital Miscellaneous Expenses: expenses incurred while Hospital Confined or as a precondition for being Hospital Confined, for services and supplies such as the cost of operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, physical therapy, therapeutic services and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
4. Surgery: Doctor's fees for inpatient surgery. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.
5. Assistant Surgeon Fees: in connection with inpatient surgery as shown in the Schedule of Benefits.
6. **Anesthetist Services: in connection with inpatient surgery.**
7. Doctor's Visits: when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.
8. Organ Transplant: including non-investigative and non-experimental human organs and tissue transplants that are Medically Necessary.

9. 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.

#### **Outpatient Expenses**

10. Day Surgery (Outpatient): Surgeon's and Assistant Surgeon's fees for outpatient surgery. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.

11. Day Surgery Miscellaneous Expenses: Includes services related to scheduled surgery performed in a Hospital, ambulatory surgical center, operating room expenses, laboratory tests and diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines; therapeutic services and supplies. Benefits will not be paid for: surgery performed in a Hospital emergency room, Doctor's office, or clinic.

12. Anesthetist Services: in connection with outpatient surgery.

13. Doctor's Visits: Includes well visits and routine GYN exams; benefits are limited to one visit per day. Benefits will not be paid when related to surgery.

14. Physical Therapy and Chiropractic Expenses: benefits are limited to one visit per day.

15. Diagnostic X-ray Services: Includes diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits, X-ray and lab procedures.

16. Medical Emergency Expenses: only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 48 hours from time of Injury or first onset of Sickness.

17. Radiation & Chemotherapy: as shown in the Schedule of Benefits.

18. Laboratory Procedures: as shown in the Schedule of Benefits.

#### **Other Expenses**

19. Ambulance Service. Payment will be made to the provider as shown in the Schedule of Benefits.

20. Braces and Appliances: 1) when prescribed by a Doctor; and 2) 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:

a. is primarily and customarily used to serve a medical purpose;

b. can withstand repeated use; and

c. generally is not useful to person in the absence of Injury.

No benefits will be paid for rental charges in excess of the purchase price.

21. Consultant Doctor Fees: when requested and approved by the attending Doctor. Covered Expenses will be paid under this benefit or under the Doctor's Visits benefit, but not for the same day.

22. Dental Treatment (Injury Only): when performed by a Doctor and made necessary by Injury to sound, natural teeth. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted dental standards of the American Dental Association.

23. The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, to the extent shown in the Schedule of Benefits, Certain maternity testing may not be covered under the Policy. The following maternity routine tests and screening exams may be payable if all of the terms and conditions of the Policy are met: a pregnancy test, CBC, Hepatitis B, Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, Pap Smear, and Glucose Challenge Test (at 24 - 28 weeks gestation), one ultrasound (subsequent ultrasounds only if they are ordered by a Doctor as Medically Necessary and if a claim is submitted with the pregnancy record and ultrasound report confirming the Medical Necessity), and for a Covered Person over age 35, AFP Blood Screening, Amniocentesis/AFP Screening, Chromosome Testing, Fetal Stress/Non-Stress tests. Pre-natal vitamins are not covered.

Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:

a. a minimum of 48 hours of inpatient care following a vaginal delivery; or

b. a minimum of 96 hours of inpatient care following delivery by cesarean section.

If the Doctor, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the Doctor in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, Doctor, nurse practitioner, nurse midwife, or physician's assistant experienced in maternal and child health, and shall include:

a. Parental education;

b. Assistance and training in breast or bottle feeding; and

c. Performance of any Medically Necessary and clinically appropriate tests. including the collection of an adequate sample for hereditary and metabolic newborn screening.

24. Routine Well-Baby Care: 1) while the baby is Hospital Confined; and 2) for routine nursery care provided immediately after birth, including treatment of diagnosed congenital and birth abnormalities.

25. Hospice Care: as shown in the Schedule of Benefits.

26. Durable Medical Equipment. Prosthetic Appliances and Medical Services: for Medically Necessary services.

#### **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 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](http://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.

#### **MEDICAL EVACUATION AND REPATRIATION**

To be eligible for this benefit, a Student must: a) be an International Student enrolled in the authorized college or school during the period for which coverage is purchased. or b) be a Eligible Domestic Student participating in a study abroad program sponsored by the College or School.

An eligible **International Student** must meet the definition of same. An International Student may also enroll his or her Dependent under this Section by payment of additional premium. As used in this Section, an **Eligible Domestic Student** means a permanent resident of the United States who is enrolled at the college or school and who is temporarily participating in international educational activities outside their Home Country.

The maximum combined benefit for Medical Evacuation and Repatriation is shown in the Schedule of Benefits.

#### ***Medical Evacuation Expense – If:***

- a. an Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness;
- b. that occurs while he or she is covered under this Policy,

We will pay the necessary Usual and Customary charges for evacuation to another medical facility or the Insured Person's Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

- a. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five or more consecutive days immediately prior to medical evacuation;
- b. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;
- c. We must approve the Usual and Customary Expenses incurred prior to the medical evacuation occurring, if applicable;
- d. No benefits are payable for Usual and Customary Expenses after the date the Insured Person's insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or 31 days after the date of termination;
- e. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and
- f. Transportation must be by the most direct and economical route.

**Repatriation Expense** - If the Insured Person dies while he or she is covered under this Policy, We will pay a benefit. The benefit will be the necessary Usual and Customary charges for preparation, including cremation, and transportation of the remains to the Insured Person's place of residence in his or her Home Country.

Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

### **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.**

### **VALUE ADDED SERVICES**

The following services are not part of the Plan Underwritten by Companion Life Insurance Company. The Dental Discount Plan, Vision Discount Plan, and Travel Assistance are value added services and are provided by CHP in cooperation with Careington Dental Network, and Davis Vision:

### **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 Careington 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, [www1.careington.com](http://www1.careington.com) to locate participating dental providers. Companion Life Insurance Company does not underwrite this plan.

### **VISION DISCOUNT PROGRAM**

For Vision Discount Benefits please go to: [www.chpstudent.com](http://www.chpstudent.com)

### **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 as stated in the schedule of benefits, 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.

### **STATE MANDATED BENEFITS**

**Mandate Disclaimer:** 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.

**Autism Spectrum Disorders** shall include coverage for pharmaceuticals, applied behavior analysis, physical therapy, speech therapy, psychology, psychiatric and occupational therapy services for the treatment of Autism spectrum disorders. Coverage for these services shall be to the extent such services are covered as any other diseases and conditions under this Policy. Applied behavior analysis shall be limited to thirty-two thousand dollars (\$32,000) per Insured Person per year. Benefits under this section shall continue until the Insured Person reaches the age of fifteen (15).

As used in this section, "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.

**Contraceptive Coverage** – For FDA-approved contraceptive drugs and devices which require a prescription on the same basis as other prescription drugs. We will not pay for the prescription drug RU 486.

**Diabetes Treatment Expense Benefit:** We will pay the Usual and Reasonable expenses incurred for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when Medically Necessary and when recommended or prescribed by a Physician: a) blood glucose monitors; b) blood glucose monitors to the legally blind; c) test strips for glucose monitors; d) visual reading and urine testing strips; e) insulin; f) injection aids; g) cartridges for

the legally blind; h) syringes; i) insulin pumps and appurtenances thereto; j) insulin infusion devices; k) oral agents for controlling blood sugar, and l) therapeutic/molded shoes for the prevention of amputation.

When Medically Necessary, this benefit includes diabetes self-management education to ensure that persons with diabetes are instructed in the self-management and treatment of their diabetes. This also includes information on the nutritional management of diabetes. The coverage for self-management education and education relating to medical nutrition therapy shall be limited to Medically Necessary visits upon the diagnosis of diabetes, where a Physician diagnosis a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher training is necessary. This education, when Medically Necessary, may be provided only by the Physician or, upon his or her referral, to an appropriately licensed and certified health care provider. This may be conducted in group settings. Coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when Medically Necessary.

We will also pay the Usual and Reasonable expenses incurred for:

a. Podiatric health care provider services as are deemed Medically Necessary to prevent complications from diabetes; and

b. Diabetes self-management training. Diabetes self-management training includes instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process. It also enables patients to understand the daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management, but excluding programs the only purpose of which are weight reduction, shall be limited to the following:

(1) Visits medically necessary upon the diagnosis of diabetes,

(2) A Physician diagnosis which represents a significant change in the symptoms or condition of the patient making Medically Necessary changes in the self-management of the patient, and

(3) Visits when reeducation or refresher training is Medically Necessary; provided, however, payment for the coverage required for diabetes self-management training shall be required only upon certification by the health care provider providing the training that the patient has successfully completed diabetes self-management training.

Diabetes self-management training shall be supervised by a Physician. Diabetes self-management training may be provided by the Physician or other appropriately registered, certified, or licensed health care professional as part of an office visit for diabetes diagnosis or treatment. Training provided by appropriately registered, certified, or licensed health care professionals may be provided in group settings where practical.

Coverage for diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall include home visits when Medically Necessary. Coverage shall also include instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist when authorized by the attending Physician of the patient when Medically Necessary.

**Early Intervention Services for Dependent Children:** We will pay for expenses incurred for early intervention services for dependent children up to Age 3. This coverage is limited to five thousand dollars (\$5,000) per dependent child.

As used in this benefit: "early intervention services " means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review. It also means 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. Section 1471 et seq.).

**Hair Protheses – Wigs –** We will cover incurred expenses for scalp hair prosthesis (wigs) worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. Coverage is limited to one per Policy Year per hair prosthesis (wig).

**Hearing Aids–** We will provide coverage for audiological services and hearing aids for Insured Persons Age 19 and over, up to the maximum benefit of \$700 per ear, per 3 year period. Coverage will be provided for Children under Age 19, up to the maximum benefit of \$1,500 per ear, per 3 year period.

**Infertility Treatment** for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years. To the extent that a health insurance contract provides reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than infertility, the tests and procedures shall not be excluded from reimbursement when provided attendant to the diagnosis and treatment of infertility. Assistive Reproductive Technologies such as in vitro fertilization is covered under this benefit.

As used in this benefit:

a. Infertility means the condition of an otherwise presumably healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year.

**Inherited Metabolic disorder – PKU - Enteral Nutrition Products (DME)** - We will provide coverage for non-prescription 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, gastro esophageal reflux, chronic intestinal pseudo-obstruction, and inherited diseases of amino and organic acids. Coverage for inherited diseases of amino and organic acids shall include food products modified to be low protein. Provided, however, that coverage shall not exceed an amount of two thousand five hundred dollars (\$2,500)

per covered member per year. When Enteral Formula is delivered through a feeding tube, We will pay the expense incurred when it is the sole source of nutrition.

**Lead Poisoning** – We will pay for expenses incurred for screening for lead poisoning and lead screening related services for children under six (6) years of age as required by department regulations and diagnostic evaluations for lead poisoning. This includes but is not limited to confirmatory blood lead testing.

**Lyme Disease Treatment:** We will cover incurred expense for diagnostic testing and long-term antibiotic treatment of chronic Lyme disease when determined to be Medically Necessary and ordered by a Physician acting in accordance with chapter 37.5 of title 5 entitled “Lyme disease diagnosis and treatment”. This is after making a thorough evaluation of the patient’s symptoms, diagnostic test results and response to treatment. Treatment otherwise eligible for benefits pursuant to this section shall not be denied solely because such treatment may be characterized as unproven, experimental, or investigational in nature.

**Mammograms and Pap Smears** – We will pay incurred expense for Mammograms and Pap Smears when recommended by a Physician for women who have been treated for breast cancer within the last 5 years. We will also cover women who 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 Treatment and Hospital Stay** - We will pay the Usual and Reasonable expenses incurred by an Insured Person for not less than forty-eight (48) hours of inpatient care following a mastectomy. And not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer. We will also pay the Usual and Customary expenses incurred for reconstructive breast surgery performed as a result of a partial or total mastectomy. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed. Provided that the reconstructive surgery and any adjustments made to the non-diseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast. Benefits will be paid for prostheses and treatment of physical complications, including lymphedemas, at all stages of Mastectomy, in consultation with the attending Physician and the patient.

**New Cancer Therapies** – We will pay incurred expense for Insured Person’s participation in an approved clinical trial for the treatment of cancer or another life-threatening disease or condition. This coverage will not deny (or limit or otherwise impose conditions on) the coverage of routine patient costs for items and services provided in connection with the trial. This coverage may not discriminate against the individual based on participation in the trial.

**Pediatric Care/Screening/Immunization**– We will pay the Usual and Reasonable expenses incurred for eligible participants who are Dependents of an Insured Student, from birth through the date the child is eighteen (18) years of age for:

a. Immunization against diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, haemophilus influenzae type B, and hepatitis A; and b. Any other immunization subsequently required for children by the Rhode Island Department of Health. Benefits will not be provided for pediatric preventive care services that are paid for or offered free of charge by the state of Rhode Island. Biologicals used for vaccinations are covered by the state of Rhode Island.

**Prostate and Colorectal Exams** – We will pay for the diagnostic testing services prostate and colorectal examinations and laboratory tests for cancer for any non-symptomatic person covered under that policy, in accordance with the current American Cancer Society guidelines.

**Smoking Cessation Programs** - We will pay for expense incurred for tobacco cessation treatments. This includes outpatient counseling for smoking cessation when provided by a qualified practitioner. If prescription drug coverage is provided under the Policy. We will also include coverage for nicotine replacement therapy or prescription drugs with no cost sharing applied. Nicotine replacement therapy includes, but is not limited to nicotine gum, patches lozenges, nasal spray and inhalers.

As used in this section, smoking cessation treatment includes the use of an over-the-counter (OTC) or prescription FDA smoking cessation medication, when used in accordance with FDA approval, for not more than two (2) courses of medication of up to fourteen (14) weeks each, annually, when recommended and prescribed by a prescriber who holds prescriptive privileges in the state in which they are licensed, and used in combination with an annual outpatient benefit of sixteen (16) one-half (1/2) hour evidence based smoking cessation counseling sessions provided by a qualified practitioner for each covered individual. Smoking cessation treatment may be redefined through regulation promulgated 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.

**Transplants - Human leukocyte antigen testing** – We will pay incurred expense for human leukocyte antigen testing. This is 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, 42 U.S.C. § 263a. At the time of the testing, the person being tested must complete and sign an informed consent form.

This form also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

## **GENERAL POLICY EXCLUSIONS**

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The Policy 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 by 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:
  5. a covered Injury that occurred while the Covered Person was insured;
  6. a covered child's congenital defect or anomaly; or as specifically provided for in the Policy.
7. Drugs and medications for the treatment of impotence and/or sexual dysfunction;
8. Expenses incurred in connection with voluntary sterilization or sterilization reversal, vasectomy or vasectomy reversal, except as specifically provided in the policy;
9. 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;
10. 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.
11. 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.
12. 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 caused by a covered Injury, and except as specifically provided in the Hospitalization and Anesthesia for Dental Procedures expense benefit or as specifically provided in the schedule of benefits;
13. Elective Surgery or Elective Treatment as defined 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. 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;
16. Weight management, weight reduction, treatment for obesity, surgery for the removal of excess skin or fat, or nutrition programs, except as related to treatment for diabetes, except as provided in the Policy.
17. 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.

## **EXTENSION OF BENEFITS**

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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 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 Lifetime Aggregate Maximum per covered Accident or covered Sickness;
3. the Covered Person obtains other coverage; or
4. the Covered Expenses are incurred more than 3 months following termination of insurance.

## **COORDINATION OF BENEFITS (COB)**

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The Policy will coordinate benefits for expenses covered by any other valid and collectible medical, health or accident insurance or pre-payment plan as stated in the Policy. Payments from such coverage and from the Plan will not be in excess of the total eligible expenses incurred.

## **NON DUPLICATION OF BENEFITS LIMITATION**

If benefits are payable under more than one (1) benefit provision contained in the Policy, benefits will be payable only under the provision providing the greater benefit.

## **CONTINUATION OF COVERAGE**

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A Covered Person who has been insured under the Policy may continue to be insured under the Policy when coverage terminates subject to the following: Continuation of Coverage is available to Insureds, and their covered Dependents, when the Insured leaves school, dies, or when the covered Dependent no longer qualifies as an eligible Dependent.



1. The Covered Person requesting coverage must have been insured under the Policy for at least 3 months. Requests for Continuation of Coverage, with the applicable premium, must be made by contacting University Health Plans at [www.universityhealthplans.com](http://www.universityhealthplans.com) before the termination of existing coverage and while the Covered Person still meets the eligibility criteria.
2. Coverage and benefits will be the same as those, which are applicable prior to continuation.
3. Premium rates for Continuation of Coverage are higher than student rates. Rates, and forms to request Continuation of Coverage, are available in the Student Insurance Office.
4. The maximum period for which coverage may be continued is 3 months.
5. Continuation of Coverage is not available to persons who are eligible for coverage under another Health Care Plan, including Medicare.

### **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 Counseling and Psychological Services for proper treatment; or
2. If away from Brown University or if Health Services or Counseling and 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 claims to Cigna, PO Box 188061, Chattanooga, TN 37422-8061.**
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](http://www.chpstudent.com) or call (800) 633-7867. Any provision of this Plan, which on the effective date, is in conflict with the statutes 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](http://www.universityhealthplans.com)

or email us at: [info@univhealthplans.com](mailto: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](http://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](http://www.chpstudent.com)

or email us at: [customerservice@consolidatedhealthplan.com](mailto:customerservice@consolidatedhealthplan.com)

**Group Number: S210207**



Your out-of-pocket costs may be lower when you utilize Cigna PPO Providers. For a listing of Cigna PPO Providers, go to [www.cigna.com](http://www.cigna.com) or contact Consolidated Health Plans at (413) 733-4540, toll-free at (800) 633-7867, or [www.chpstudent.com](http://www.chpstudent.com) for assistance.

**If your current provider does not participate in the Cigna PPO Network you may continue to use the First Health Network but all claims must be submitted to Cigna first. You can find a provider at [www.firsthealthbp.com](http://www.firsthealthbp.com).**

For a copy of the Company's privacy notice, go to:

[www.consolidatedhealthplan.com/about/hipaa](http://www.consolidatedhealthplan.com/about/hipaa) or [www.brown.edu/insurance](http://www.brown.edu/insurance) or [www.universityhealthplans.com](http://www.universityhealthplans.com)

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](http://www.express-scripts.com)

This plan is underwritten by:

**Companion Life Insurance Company as policy form BSHP-POL**

**Policy Number: 201615A90**