

**STUDENT
ACCIDENT AND
SICKNESS
INSURANCE
PROGRAM**

For students of

**Roger Williams
University**

**Bristol, Rhode Island
Providence, Rhode Island**

2008-2009

Underwritten by
**Security Mutual Life Insurance Company
of New York**

Policy Number: 2008I5A23

This brochure is for informational purposes only. All benefits are subject to the deductibles, co-payment, coinsurance, limitations and any other provisions of the Policy.

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Schedule of Medical Expense Benefits Center Fold

ELIGIBILITY

All resident students and all international students are automatically enrolled in the insurance plan at registration. All other registered Day Students who are enrolled on a full-time basis and have paid the Health Service Fee, are eligible to enroll in the insurance plan on a voluntary basis.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, or 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 the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

EFFECTIVE AND TERMINATION DATE

The Master Policy on file at the school becomes effective at 12:01 a.m., August 14, 2008. Individual Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 12:01 a.m., August 14, 2009. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

Refunds of premiums are allowed only upon entry into the armed forces or withdrawal from school within the first 31 days for other than medical reasons.

The Policy is a Non-Renewable, One-Year Term Policy.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the policy ceases on the termination date. However, if an Insured is hospital confined on the termination date from a covered injury or sickness for which benefits were paid before the termination date, covered medical expenses for such injury or sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the termination date.

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

STATE MANDATED BENEFITS

State Mandated benefits will be subject to all deductible, co-payment, coinsurance, limitations, or any other provisions of the policy, unless specifically stated otherwise.

Pediatric Preventive Care Expense Benefit – We will pay the expenses incurred for preventive and primary care services rendered to a child who is a Dependent covered under the Policy. These benefits will be payable for expenses incurred from birth through the 31 days that a newborn child is covered under the policy. Covered services are those services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics.

Mental Illness and Substance Abuse Expense Benefit:

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

Outpatient Expense – When the Insured Person does not require Hospital Confinement for the treatment of a Mental Illness or substance abuse, We will pay the Usual and Customary charges incurred on the same basis as for any other Covered Sickness, according to the following schedule:

1. Outpatient Mental Illness services, with the exception of outpatient medication visits will be provided for up to 30 visits in any Policy year.
2. Outpatient services for substance abuse treatment will be provided for up to 30 hours in any Policy year.
3. Community residential care services for substance abuse treatment will be provided for up to 30 days in any Policy year; and
4. Detoxification benefits will be provided for up to five (5) detoxification occurrences or 30 days in any Policy year, whichever comes first.

Outpatient services must be furnished by:

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

As it pertains to this benefit, Mental Illness means any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization. Such disorder must substantially limit the life activities of the person with the illness. However, tobacco and caffeine are hereby excluded from the definition of “substance” for the purpose of this provision.

Mental Illness does not include:

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

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

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 25 and 42 who is unable to conceive or sustain a pregnancy during a period of one (1) year. We will pay the Reasonable and Customary Expense incurred on the same basis as any other Sickness.

Mastectomy Expense – 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.

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) lancets and automatic lancing devices; (b) glucose test strips; (c) blood glucose monitors; (d) blood glucose monitors for visually impaired; (e) control solutions used in blood glucose monitors; (f) diabetes data management systems for management of blood glucose; (g) urine testing products for glucose and ketones; (h) oral anti-diabetic agents used to reduce blood sugar levels; (i) alcohol swabs; (j) syringes; (k) injection aids including insulin drawing up devices for the visually impaired; (l) cartridges for the visually impaired; (m) disposable insulin cartridges and pen cartridges; (o) insulin pumps and equipment for the use of the pump including batteries; (p) insulin infusing devices; (q) oral agents for treating hypoglycemia such as

glucose tablets and gels; (r) glucagon for injection to increase blood glucose concentration; (s) other diabetes equipment and related supplies that are medically necessary for the treatment of diabetes. We shall provide coverage, when medically necessary and prescribed by a Doctor for diabetes self-management education to ensure that the Insured Person is instructed in the self-management and treatment of their diabetes, and coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when medically necessary.

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

Covered services include the following services as needed: physical therapy, occupational therapy as a rehabilitative service, respiratory service, speech therapy, medical social work, nutrition counseling, the services of a home health aide, drugs and medications, medical and surgical supplies such as dressings, bandages and casts, minor medical equipment such as commodes and walkers, laboratory testing, X-rays and E.E.G. and E.K.G. evaluations.

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

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 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 biotechnical and/or pharmaceutical industry or manufactures of medical devices.

Mammography Expense (Payable as a Sickness Benefit Only) – The Company will pay the expenses incurred for mammography charges as follows:

1. 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).
2. One (1) baseline mammogram for any women 35 through 39 years of age, inclusive;
3. A mammogram every other year for women age 40 through 49, inclusive or more frequently upon recommendation of a physician; or
4. A mammogram every year for any woman age 50 or over.
5. As it pertains to this benefit, **at risk** means that a woman: has a personal history of breast cancer; the woman has a person history of biopsy-proven benign breast disease; or The woman's mother; sister or daughter has or has had breast cancer.

Cytological Screening Expense Benefit - If an Insured Person requires cytological screening (pap smear), We will pay the following: a cytological screening once a year or more frequently if recommended by a Doctor. Such benefits will include the examination, laboratory fee and the Doctor's interpretation of the laboratory results.

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

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.

Postpartum Hospital Stay Expense – When Hospital Confinement is as the result of pregnancy, The Company will pay the expenses incurred for a minimum of 48 hours following a vaginal birth and 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.

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.

Benefits for Contraceptive Drugs and Devices - Benefits will be paid the same as any other outpatient Prescription Drug for prescription contraceptive drugs and devices approved by the Food and Drug Administration (FDA). Benefits will not be provided for the Prescription Drug RU 486. Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Off-Label Drug Treatments – When prescription drugs are provided as a benefit of the Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions 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

(1) of the following: (a) The American Medical Association Drug Evaluations; (b) The Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or (d) 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.

Orthotic and Prosthetic Services -- 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. The benefits provided under this provision are the same as benefits provided under federal laws (42 U.S.C. sections 1395K, 1395I 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.

Hearing Aids - Benefits will be paid up to \$1500 per individual hearing aid, per ear, every three (3) years for an Insured Person under age 19. Benefits will be paid up to \$700 per individual hearing aid, per ear, every three (3) years for an Insured Person over age 19. Hearing aid means any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including but not limited to FM devices.

Tobacco Cessation Treatment - Benefits will be paid for approved nicotine replacement therapy recommended and prescribed by a prescriber who holds prescriptive privileges in the state, when used in combination with annual outpatient benefits of eight (8) one half (1/2) hours sessions of smoking cessation counseling by a qualified practitioner as described in RI Title 27, Chapter 18, section 66.

Scalp Hair Prosthesis - Benefits will be paid for hair loss suffered as a result of the treatment of any form of cancer or leukemia subject to the same limitations and guidelines as other prostheses and not to exceed \$350 per covered member per year, exclusive of any deductible.

MAJOR MEDICAL BENEFITS
\$48,500 MAXIMUM BENEFIT
(FOR EACH INJURY OR SICKNESS)

The Major Medical Benefit begins payment after the Basic Maximum Benefit of \$1,500 has been paid by the Company. The Company will pay 80% of additional Covered Medical Expenses incurred up to the Major Medical Maximum of \$48,500. The total benefit payable under Major Medical is \$50,000 minus the Basic Benefits already paid.

No benefits will be paid under Major Medical for: 1) Room and board expenses which exceed the semi-private room rate for Injury or Usual and Customary charge; maximum for Sickness; 2) Dental treatment; 3) Services designated as "No Benefits" in the Basic Medical Expense Benefits Schedule of Benefits; and 4) Outpatient Physiotherapy.

MEDICAL EVACUATION BENEFIT

If as the result of a Covered Injury or Sickness, a Covered Person was hospital confined for a minimum of five (5) days, and must be transported to their country of origin, the Policy will pay up to \$10,000. Such evacuation will require prior approval of both the attending physician and the Company. Upon evacuation for International Students, all coverage under the Policy shall terminate.

REPATRIATION BENEFIT

If a Covered Person dies as the result of a Covered Injury or Covered Sickness, the Policy will pay up to \$10,000 for the preparation and transportation of the body to the home country of the Covered Person. This benefit does not pay for any person accompanying the body.

DEFINITIONS

Covered Injury means a bodily Injury that is;

1. sustained by an Insured Person while he/she is insured under this Policy or the School's prior policies; and
2. caused by an accident directly and independently of all other causes.

Coverage under the School's policies must have remained continuously in force from the date of Injury until the date services or supplies are received for them to be considered as a Covered Medical Expense under the Policy. All Injuries sustained by one (1) person in any one (1) accident, including all related conditions and recurrent symptoms of these Injuries are considered a single Covered Injury.

Pre-existing Condition means any Injury or any Sickness or condition which was contracted or which manifested itself or for which a licensed Physician was consulted or for which treatment or medication was prescribed within 12 months prior to the Insured Person's effective date of coverage under the Policy.

Reasonable and Customary Expenses means fees and prices generally charged within the locality where performed for medically necessary services and supplies required for treatment of cases of comparable severity.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which causes a loss while the Policy is in force and which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Sickness includes Complications of Pregnancy. Sickness will also include normal pregnancy when conception occurs during the term coverage.

Medically Necessary means medical and dental services, treatments or supplies that are:

1. Recommended by a Physician;
2. Consistent with accepted medical practice for the Injury or Sickness;
3. Generally considered by Physicians in the United States of America to be appropriate for the Injury or Sickness; and
4. Generally considered by Physicians in the United States of America to be appropriate for the Injury or Sickness; and
5. Accepted as safe, effective and reliable by a medical specialty or board recognized by the American Board of Medical Specialties.

A medical or dental treatment will not be deemed Medically Necessary if any service, supply or treatment used or provided in connection with the Injury or Sickness is Experimental or Investigational in nature.

If services do not meet the criteria above or are not consistent with professionally recognized standards of care with respect to quality, frequency or duration, such services will not be deemed to be Medically Necessary.

EXCLUSIONS AND LIMITATIONS

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

1. Acne; acupuncture; allergy, including allergy testing;
2. Addiction, such as nicotine addiction except as otherwise provided under the policy;
3. Assistant Surgeon Fees;
4. Learning disabilities, except as specifically provided in the Benefits for Treatment of Mental Illness and Substance Abuse;
5. Biofeedback;
6. Chemotherapy; Radiation Therapy;

7. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;
8. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
9. Elective Surgery or Elective Treatment;
10. Eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery; except when due to a disease process;
11. Foot care including: care of corns, bunions (except capsular or bone surgery), calluses;
12. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process, except as mandated by the state of Rhode Island;
13. Alopecia;
14. Immunizations; preventive medicines or vaccines, except where required for treatment of a covered Injury;
15. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
16. Injury sustained while (a) participating in any interscholastic, club, intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
17. Organ transplants, including organ donation;
18. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
19. Prescription Drugs, services or supplies as follows (except as mandated by the state of Rhode Island.):
 - a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use;
 - b. Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in Benefits for Off-Label Drug Use for Cancer Treatment;
 - d. Products used for cosmetic purposes;
 - e. Drugs used to treat or cure baldness; anabolic steroids used for body building;

- f. Anorectics - drugs used for the purpose of weight control;
 - g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
 - h. Growth hormones; or
 - i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
20. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; except as specifically provided in the Benefits for Treatment of Infertility as mandated by the state of Rhode Island; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
 21. Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
 22. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
 23. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
 24. Skeletal irregularities of one (1) or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery;
 25. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
 26. Sleep disorders;
 27. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
 28. Supplies, except as specifically provided in the policy;
 29. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy in connection with a mastectomy;
 30. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

31. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
32. Weight management, weight reduction, nutrition programs, treatment for obesity, or surgery for removal of excess skin or fat.

PREEXISTING CONDITIONS LIMITATION

Preexisting conditions are not covered until the Insured person has been: 1) Continuously insured for a period of 12 months without a Physician being consulted or a treatment or medication prescribed; or 2) Continuously Insured in the School's Student Accident and Sickness Insurance Plan for 12 months.

As it pertains to this limitation, **Continuously Insured** means that the Insured Person has been continuously insured under this Policy or prior Qualifying Coverage without a break of more than 30 days.

COORDINATION OF BENEFITS

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

ROGER WILLIAMS HEALTH SERVICES

Anne Andrade, R.N. P Director
 Brenda Bishop, R.N.P
 Carline Fleig, R.N.P.
 Marjorie Bobola, R.N.
 Geoffrey Hamilton, M.D.
 James Ross, M.D.
 Karen Lebreux - Administrative Assistant
 Ana Cabral - Medical Assistant
 Jennifer Sylvia - Receptionist

HOURS

Monday through Friday
 8:30 a.m. to 5:00 p.m.
 By Appointment 254-3156

The Roger Williams University Health Services is committed to wellness in addition to providing care and appropriate referral during a sickness. They encourage health practices which promote physical and emotional well-being.

Services are available by appointment. The services include but are not limited to:

1. Physical assessment and treatment and/or referral for Illness or Injury
2. Gynecological examination and Contraception
3. Health Education and Counseling
4. Immunizations

5. Physician on campus Tuesday and Friday
6. Pharmacy Services
7. Laboratory Services

The Health Services is located at the Center for Student Development. During hours when the Health Services is closed, emergency care is available at the Bristol County Medical Center, Newport Hospital and Rhode Island Hospital. If you have any emergency, contact the R.A. on duty in your dormitory or Security at Extension 4357 or 254-3611.

The services provided by the Health Services are not in any way connected with or underwritten by Security Mutual Life Insurance Company of New York.

ALTERNATE COVERAGE

If you do not meet the eligibility requirements of this student policy, please call 800-385-9622 for information on alternative coverage.

CLAIMS PROCEDURE

In the event of injury or sickness, students should:

1. Report at once to the Health Services for treatment or referral, or when not in school, to the nearest doctor or hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, identification number and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one (1) year will not be considered for payment except in the absence of legal capacity.

HOW TO FILE AN APPEAL

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an insured student who disagrees with how a claim was processed may appeal that decision. The student must request an appeal in writing within 180 days of the date appearing on the EOB. The appeal request must include why they disagree with the way the claim was processed. The request must include any additional information they feel supports their request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator at the address on the next page.

THIS PLAN IS UNDERWRITTEN BY:

Security Mutual Life Insurance Company of New York
Binghamton, NY
As Policy form SMLBH-260 (Rev05)(RI/RW)

SUBMIT ALL CLAIMS OR INQUIRIES TO THE CLAIMS ADMINISTRATOR:

Consolidated Health Plans
2077 Roosevelt Avenue
P.O. Box 1998
Springfield, Massachusetts 01101-1998
413-733-4540
800-633-7867

PLAN MARKETED BY:

Risk Strategies Company
10 Dorrance Street
Suite 505
Providence, Rhode Island 02903
401-831-1463
800-385-9622

Representations of this plan must be approved by the Company.

For a copy of the privacy notice you may:
go to

www.chpstudent.com/hipaamain.htm

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)

ONLINE SERVICES

Please visit our Website at www.chpstudent.com to view and print Brochures, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services.

Please keep this brochure as a general summary of the insurance. The Master Policy on file at the school contains all of the provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. The Master Policy is the contract and will govern and control payment of benefits.

THIS BROCHURE IS BASED ON
POLICY # 2008I5A23

Emergency Medical and Travel Assistance

MEDEX Assistance Corporation provides you with a comprehensive program with 24/7 emergency medical assistance including emergency evacuation and repatriation and other travel assistance services when you are 100 or more miles away from home. Your MEDEX identification card is your key to travel security.

For general inquiries regarding your international assistance coverage, please call Consolidated Health Plans at 800-633-7867.

If you have a medical or travel problem, simply call MEDEX 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: 800-527-0218 or if you are in a foreign country, call collect at: 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.