Student Health Insurance
Designed Specifically for the Students of
The University of Rhode Island

2013-2014

Underwritten by:
Monumental Life Insurance Company
Cedar Rapids, IA
a Transamerica company

Policy Number: CRI203J
International: August 15, 2013 to August 14, 2014
Domestic: September 1, 2013 to August 31, 2014

''Your student health insurance coverage, offered by Monumental Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. If you have any questions or concerns about this notice, contact Bollinger Insurance Services, Short Hills, NJ, 1-866-267-0092. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.''

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IMPORTANT: All insurance companies and group health plans must use the same standard Summary of Benefits and Coverage ("SBC") form to help you compare health plans. You should review your SBC before enrolling in coverage by logging onto www.BollingerColleges.com/URI. You may also request a copy from Bollinger by contacting them at 1-866-267-0092.

STUDENT HEALTH SERVICES (SHS)

The Student and Spouse should use the resources of the U.R.I. Health Services where treatment will be administered for best coverage. Dependent children are not eligible to use the SHS.

U.R.I. HEALTH SERVICES*

Hours of Operation

Monday – Friday 8:00 a.m. to 8:00 p.m. Appointments available 9:00 a.m. to 7:15 p.m.
Saturday – Sunday – Holidays:
10:00 a.m. to 4:00 p.m. Physician and Pharmacy available 12:30 p.m. to 4:00 p.m.
Closed: Thanksgiving, Spring and Summer Break
*Please visit our website @ www.health.uri.edu for updated information

- For medical emergencies requiring an ambulance on campus: Call 24 hours a day: 874-2121
- For a new illness/condition, call: 874-4763
- For Women's Clinic, call: 874-5151
- For other medical appointments (follow-up, etc.), call: 874-4763
- For other services or inquiries, call: 874-2246
- TTY RI Relay is available by calling: 1-800-745-5555

AM I ELIGIBLE?

All full-time Undergraduate Students who are enrolled in 12 or more hours and all Graduate Students taking 9 or more hours are automatically enrolled in this insurance plan unless proof of comparable coverage is provided by completing the online waiver by the waiver deadline.

All International Students are automatically enrolled in this insurance plan unless proof of comparable coverage is provided.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirement 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 that the Eligibility requirements have not been met, its only obligation is to refund the premium.

COVERAGE FOR DEPENDENTS

Students may enroll their eligible Dependents at an additional cost. Dependent means: the Spouse, husband/wife or domestic partner (including same sex civil union partners), of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain age twenty-six (26).

Newborn infant means any child born to an Insured Student 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. The Insured will have the right to continue such coverage for the child beyond the first thirty-one (31) days.

To continue the coverage the Insured must, within thirty-one (31) days after the child's birth, complete and return the Dependent Enrollment Form. Students who wish to add their dependents may visit www.health.uri.edu and click on the insurance link to download the enrollment form.

Dependent eligibility expires concurrently with that of the Insured Student.

If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of thirty-one (31) days after the child's birth .

HOW DO I WAIVE/ENROLL?

If you are eligible to be covered under this program, you are automatically enrolled unless proof of comparable coverage is provided. If you presently have comparable health insurance and wish to waive the student plan offered by the University, you must complete an online waiver. To complete the online waiver, please log on to www.health.uri.edu and select insurance waiver. Fill in all required fields and submit the form. The deadline for completing the online waiver is October 4, 2013 for the fall 2013 term.

You may enroll in this Insurance Program or waive the Insurance prior to the start of the school year, or during the thirty-one (31) day period beginning with the date you become eligible under this Plan; this is known as the Open Enrollment Period.

If you are eligible for coverage and wish to enroll in the Plan outside of these enrollment opportunities, you must present documentation from your former insurance company that it is no longer providing you with personal Accident and Sickness insurance coverage. Your Effective Date of coverage under this Insurance Program will be the date that your former insurance expired, but only if you make the request for coverage within thirty-one (31) days from the date that your previous plan expired. Otherwise, the Effective Date of coverage under this Insurance program will be the first (1st) of the month following our receipt of your written request for coverage. The appropriate premium must accompany your application for coverage. Contact Bollinger to speak to the college enrollment manager.

EFFECTIVE/TERMINATION DATES AND COSTS

The University of Rhode Island Student Accident and Sickness Insurance Plan provides coverage to students for a twelve (12) month period. Coverage becomes effective on September 1, 2013 for Domestic Students, and August 15, 2013 for International Students. The individual Student's 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. Coverage will terminate on August 31, 2014 for Domestic Students and on August 14, 2014 for International Students. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured Student or extended beyond that of the Insured Student.

	Annual	Spring
Student	$1,636*	$1,014*
Spouse	$3,207*	$2,034*
Child(ren)	$2,421*	$1,540*

***The above rates include a $15 Administration Fee.**

PREMIUM REFUND POLICY

Except for medical withdrawal due to a covered Injury or Sickness, any Insured Student withdrawing from the College during the first thirty-one (31) days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such thirty-one (31) days will remain covered under the Policy for the full period for which premium has been paid and will not receive a refund for any portion of the policy.

Coverage for an Insured Student entering the armed forces of any country will terminate as of the date of such entry. Students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request.

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

DEFINITIONS

ACTUAL CHARGE means the fee charged by the Physician or Hospital for a covered service.

ALLOWABLE CHARGE means the contracted amount that the Preferred Provider Organization agrees to accept as payment in full. Covered Medical Expenses incurred at a non-Preferred Provider Organization will be based on the Usual and Customary Charge.

AGGREGATE MAXIMUM BENEFIT means benefits per Policy Year which are payable throughout a period of continuous coverage. Benefits will terminate at the end of a period of continuous coverage, subject to an Aggregate Maximum Benefit as shown on the Schedule of Benefits.

COINSURANCE means the out-of-pocket expenses to be paid by the Insured as a percentage of the Covered Medical Expenses.

COMPLICATIONS OF PREGNANCY means conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as:
(1) acute nephritis;
(2) nephrosis;
(3) cardiac decompensation;
(4) missed abortion;
(5) non-elective cesarean section;
(6) ectopic pregnancy which is terminated;
(7) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible;
(8) pernicious vomiting;
(9) pre-eclampsia;
(10) similar medical and surgical conditions of comparable severity.
It does not include:
(1) false labor;
(2) occasional spotting;
(3) physician prescribed rest;
(4) morning sickness; and
(5) similar conditions associated with the management of a difficult pregnancy not constituting a medically distinct complication of pregnancy.

CONFINED OR CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital and is charged room and board by the facility. The Insured must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. The term “Inpatient” is the same as Confined under this Policy.

Confinement does not include treatment received in the Outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

CONTINUOUS COVERAGE means that period of time during which the Insured Person is continuously covered under one of the University of Rhode Island Student Injury and Sickness Plans, with no lapse in coverage between this policy and the prior policies.

COSMETIC and RECONSTRUCTIVE PROCEDURES and SERVICES means (1) procedures and related services that are performed to reshape structures of the body in order to alter a person's appearance; and (2) procedures and related services that are performed on structures of the body to improve/restore bodily functions or appearance resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

COVERED MEDICAL EXPENSES are usual, customary, and Medically Necessary charges that are:
(1) not in excess of the maximum amount payable for services as specified in the Schedule;
(2) in excess of any deductible amount; and
(3) incurred while the Covered Person's coverage under this Policy is in force.

COVERED PERSON means the Insured or a Dependent for whom an application has been received and the required premium has been paid.

COVERED SERVICES mean services by or under the direct supervision of a Physician or licensed psychologist, when performed in a Physician's or licensed psychologist's office, hospital, in a community mental health facility or in an alcoholism treatment facility.

DEDUCTIBLE means the dollar amount of Covered Medical Expenses that must be paid as an out-of-pocket expense by each Covered Person per Policy Year before benefits are payable under this Policy. The Deductible Amount is shown on the Schedule. Under certain conditions, the Deductible Amount may be lowered or waived by the Company.

DEPENDENT means the Insured's spouse, unless they are legally separated, the Insured's children, including adopted and foster children, under the age of 26; and children whose support is required by a court decree. Children include natural children, stepchildren, legally adopted children and children placed with the Insured for the purpose of adoption. Newborn children are covered immediately from birth and adopted children are covered from the moment of placement as certified by the public or private agency making the placement. They must be primarily dependent on the Insured for support and maintenance and must live in a parent-child

relationship with the Insured. A spouse or child who is covered under this Policy as an Insured will not be eligible as a Dependent. If a husband and wife are both insured as Students, a child will be the Dependent of only one.

ELECTIVE SURGERY AND ELECTIVE TREATMENT means any surgery or treatment that is not Medically Necessary, including any service, treatment, or supply that is deemed by us to be research or experimental; or is not recognized as generally accepted medical practice in the United States. Elective Surgery and Elective Treatment do not include any procedures deemed a Medical Necessity. Elective Surgery does not mean a Cosmetic Procedure required to correct an Injury for which benefits are otherwise payable under this Policy.

Elective Surgery and Elective Treatment includes, but is not limited to, acupuncture; breast implants; breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the Policy, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are
otherwise payable under the Policy; deviated nasal septum, including submucous resection and/or other surgical correction; fertility tests; hair growth or removal; impotence; organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities except for prescription drugs prescribed by a physician to treat such disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind) with the exception of screening, counseling or behavioral interventions for the treatment of obesity and except for the treatment of an underlying covered Sickness; premarital examinations; sexual reassignment surgery, skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction (TMJ); tubal ligation; vasectomy; and weight loss or reduction.

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under this Policy. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

INSURED means those persons who are registered as participants with the Policyholder and for who the proper premium payment has been made.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in death, permanent placement of the Covered Person's health in jeopardy, serious impairment of bodily functions or

serious and permanent dysfunction of any body organ or part. Expenses incurred for a medical emergency will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor injuries or minor sicknesses.

MEDICALLY NECESSARY means care which a Physician has determined to be certifiably essential for the diagnosis or treatment of a Sickness or Injury. This determination must be based on objective results produced by an examination of the Covered Person's demonstrable symptoms. The Physician's treatment plan may be reviewed by an impartial third party whose determination will be binding on us and the Insured.

SICKNESS means an illness or trauma related disorder due to Injury which causes a loss while this 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. It also includes Pregnancy and Complications of Pregnancy.

USUAL AND CUSTOMARY CHARGE means the charge which in the Company's experience is most often incurred for any given procedure. In no event shall the Company's payment for surgical procedures exceed the Usual and Customary Charges which in the Company's experience are normally made by the majority of Physicians in that area.

PREFERRED PROVIDER INFORMATION

The URI 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 of using Preferred Providers is that these providers have agreed to accept a predetermined fee or Preferred Allowance as payment in full for their services. Consequently, when Insured Persons use Preferred Providers, out-of-pocket expenses will be lower because any applicable coinsurance will be based on a Preferred Allowance. The Insured Person should be aware that Preferred Provider Hospitals might be staffed with Out-of-Network Providers. As a result, receiving services or care from an Out-of-Network Provider at a Preferred Provider Hospital does not guarantee that all charges will be paid at the Preferred Provider level of benefits. The participation of specific providers in the Preferred Provider Networks is subject to change without notice. Insured Persons should always confirm when making an appointment that the provider participates in a Preferred Provider Network.

First Health Network is the Preferred Provider Network and provides access to providers located across the United States. To determine if a provider participates in First Health, students can call (888) 685-7774 or visit www.myfirsthealth.com. It is important that Insured Persons verify that their

providers are Preferred Providers each time they call for an appointment or at the time of service.

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.

MATERNITY TESTING

The following maternity routine tests and screening exams will be considered, if all other policy provisions have been 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, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/AFP Screening; and Chromosome Testing. Fetal Stress/Non- Stress tests are payable. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call Bollinger at 1-866-267-0092.

SCHEDULE OF BENEFITS

The Policy provides benefits for the Usual and Customary (U&C) Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to a Maximum Benefit of $500,000 Aggregate Maximum benefit per Policy Year.
If care is received from an In-Network Provider, any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency or a Preferred Provider is not located within the 40-mile range, or the hospital or health care facility is a PPO but its emergency staff/on-call providers is not, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.
Covered Medical Expenses at URI Health Services are paid at 100% (Deductible does not apply).
Benefits will be paid up to the Maximum Benefit for each service as shown in the schedule below. All benefit maximums are combined Preferred Provider and Out-of-Network, unless otherwise noted below. Covered Medical Expenses include:

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Aggregate Maximum Benefit	**$500,000**	
Deductible*[1] (Per Insured Person) (Per Policy Year), (deductible will not apply if a Preferred Provider is not located within a 40-mile radius or the hospital or health care facility is a Preferred Provider but the emergency room staff/on-call providers is not).	$0	$200
INPATIENT BENEFITS		
Room and Board*[1], daily semi-private room rate, general nursing care provided by the hospital, or intensive care unit.	90% of Allowable Charge	60% of U&C Charges
Hospital Miscellaneous*, such as the cost of the operating room, laboratory tests and procedures, x-ray examinations, injections, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services, and supplies. Including skilled nursing and sub-acute care.	90% of Allowable Charge	60% of U&C Charges
Routine Newborn Care*[1]	Paid as any other Sickness, 48/96 hours maximum	
Physiotherapy*	90% of Allowable Charge	60% of U&C Charges
Surgery*[1]	90% of Allowable Charge	60% of U&C Charges
Assistant Surgeon*	20% of Surgeon's Fee	
Anesthetist*	75% of Charges	75% of Charges
Pre-Admission Testing*[1]	Paid under Hospital Misc.	
Registered Nurse*[1]	80% of Allowable Charge	60% of U&C Charges
Physician Visit*[1], does not apply when related to surgery.	90% of Allowable Charge	60% of U&C Charges
Mental Illness*[1], limited to 90 days.	90% of Allowable Charge	60% of U&C Charges
Substance Abuse*[1] - Limited to thirty (30) days of community residential care services within a Policy Year (or partial/day treatment not to exceed above benefit). - Detoxification benefits will be paid for up to five (5) detoxification occurrences or thirty (30) days in any Policy Year, whichever comes first.	90% of Allowable Charge	60% of U&C Charges

OUTPATIENT BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Surgery*	90% of Allowable Charge	60% of U&C Charges
Day Surgery Miscellaneous*1, related to scheduled surgery performed in a hospital or Out patient Surgical Center, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies.	90% of Allowable Charge	60% of U&C Charges
Anesthetist*	75% of Charges	75% of Charges
Assistant Surgeon*	20% of Surgeon's Fee	20% of Surgeon's Fee
Outpatient Miscellaneous*1	90% of Allowable Charge	60% of U&C Charges
Emergency Room*1, use of the emergency room and supplies. Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.	$100 Co-pay per visit then 90% of Allowable Charge (Co-pay waived if admitted within 24 hours)	$100 Deductible per visit** then 90% of U&C Charges. (Per visit deductible waived if admitted)
Diagnostic X-Ray and Laboratory Services*, includes radiation therapy and chemotherapy, CT scans, MRIs and PET scans.	90% of Allowable Charge 100% at University Health Services	60% of U&C Charges
Tests & Procedures*, diagnostic services and medical procedures performed by a physician, other than physician visits, physiotherapy, x-rays and laboratory procedures. Including dialysis and filtration procedures.	Paid under Outpatient Miscellaneous	Paid under Outpatient Miscellaneous
Physician's Visit*1, includes Wellness and preventive exams; (deductible does not apply), hearing tests, speech tests, allergists and dermatology. Physician visits do not apply when related to surgery or physiotherapy.	$20 Co-pay per visit, then 90% of Allowable Charge 100% at University Health Services	$30 Deductible** per visit, then 60% of U&C Charges
Immunizations and/or titers(deductible does not apply)	90% of Allowable Charge 100% at University Health Services	60% of U&C Charges
STI Screening (deductible does not apply)	90% of Allowable Charge 100% at University Health Services	60% of U&C Charges
Eye Exam, limited to one (1) annual routine eye exam.	$20 Co-pay, then 90% of Allowable Charge	$30 Deductible**, then 60% of U&C Charges
Chiropractic Care*1, limited to twelve (12) treatments per Policy Year.	$20 Co-pay per visit, then 90% of Allowable Charge	$30 Deductible** per visit, then 60% of U&C Charges
Physiotherapy (Physical Therapy) / Occupational Therapy*1, limited to one (1) visit per day.	90% of Allowable Charge	60% of U&C Charges
Injections*, when administered in the physician's office and charged on the physician's statement.	Paid under Outpatient Miscellaneous 100% at University Health Services	

ADDITIONAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Mental Illness[*1], outpatient services, except outpatient medication visits, up to thirty (30) visits per Policy Year. (Limited to one (1) visit per day).	$20 co-pay per visit,then 90% of Allowable Charge	$30 deductible** per visit then 60% of U&C Charges
Outpatient Substance Abuse Treatment[*1], paid up to thirty (30) hours per Policy Year. (Limited to 1 visit per day).	$20 co-pay per visit, then 90% of Allowable Charge	$30 deductible** per visit then 60% of U&C Charges
Maternity / Complication of Pregnancy[*]	Paid as any other Sickness	
Voluntary Termination of Pregnancy[*]	100% Allowable Charge	60% U&C Charges
Hospice Care	90% of Allowable Charge	60% of U&C Charges
Motor Vehicle Injury	90% of Allowable Charge	60% of U&C Charges
Ambulance Service[*1]	90% of Allowable Charge	80% of U&C Charges
Dental Injury[*1], benefits paid for Injury to sound natural teeth and removal of impacted wisdom teeth only. (Excludes x-rays and anesthesia).	$150 per tooth for simple extraction; $250 per tooth for complicated extraction; or $300 per tooth for repair due to a covered Injury	
Dental Care, limited to Students age 19 and under	100% U&C Charges for one examination and two cleanings per Policy Year.	
Durable Medical Equipment, Braces, and Appliances*1, a written prescription must be submitted with the claim.	90% of Allowable Charge	80% of U&C Charges
Physician Consultant Fees[*]	Paid under Outpatient Miscellaneous 100% at URI Health Services	
Emergency Medical Evacuation, Repatriation and Global Emergency Medical Assistance Services:	100% of Actual Charge Medical Evacuation - $50,000 max Repatriation of Remains - $20,000 max Services are provided by On Call and must be approved in advance by Bollinger for reimbursement.	

Prescriptions

Prescriptions are covered at the Health Center at 100% after a $20 co-pay; $0 co-pay for generic contraceptives. Prescriptions are covered at all CVS Caremark pharmacies, subject to a $20 co-pay per covered prescription. **See section in brochure called CAREMARK.**

* Deductible(s) applies as defined.
**The out-of-network per visit deductible is in addition to the Policy deductible.
[1] Refer to Policy on file at the University for detail for limitations, exclusions, and definitions.

PRE-CERTIFICATION POLICY

This plan does not require pre-certification of benefits. Please refer to the schedule of benefits section of the policy for covered benefits.

EXTENSION OF BENEFITS

The coverage provided under this Policy ceases on the termination date. However, if a Covered Person is Totally Disabled on the termination date from a covered Injury or Sickness, Covered Medical Expenses for such Injury or Sickness will continue to be paid until the Covered Person is no longer Totally Disabled, but not to exceed 90 days from the expiration date of coverage, or the Maximum Policy benefit, whichever occurs first. Covered Medical Expenses for maternity care for a pregnancy which commenced while the Policy was in effect, shall be continued for the period of that pregnancy and will not be based upon total disability.

The total payments made in respect of the Covered Person for each condition both before and after the termination date will never exceed the Maximum Benefit.

CAREMARK

The prescription drug benefit utilizes CVS/Caremark. There is a $20 co-pay per prescription. When obtaining a covered prescription, please present your Caremark Pharmacy ID card. Caremark will bill Bollinger for the cost of the drug, plus a dispensing fee. When you need to fill a prescription and do not have your ID card with you, you must pay for your prescription and be reimbursed by submitting a completed Caremark claim form directly to Caremark. You will be reimbursed for covered medications directly by Caremark. Caremark Customer Service may be contacted at 1-800-391-6443 or online at www.caremark.com. If you need additional assistance or have a question about the benefits or other plan questions, please contact the Plan Administrator, Bollinger, Inc., at 1-866-267-0092.

MANDATED BENEFITS

All Policy provisions, including benefit maximums, coinsurance amounts, limitations, exclusions, and general provisions apply unless specifically stated otherwise.
(Note: Wellness/preventive benefits under the Affordable Care Act (ACA) are required to meet federal regulations. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate. Please see the Schedule of Benefits for coverage details.)

AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Sickness and is subject to medical necessity and appropriateness.

Coverage is provided for applied behavior analysis, physical therapy, speech therapy and occupational therapy services for the treatment of Autism spectrum disorders. Benefits shall continue until the covered person reaches age fifteen (15).

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

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

BENEFITS FOR CONTRACEPTIVES

Benefits will be paid for 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 FOR DIABETES TREATMENT

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the treatment of all types of diabetes, if recommended or prescribed by a Physician. Benefits shall include coverage for the following equipment and supplies for the treatment of diabetes: blood glucose monitors and blood glucose monitors for the legally blind, test-strips for glucose monitors and/or visual reading, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar, and therapeutic/molded shoes for the prevention of amputation.

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

BENEFITS FOR EARLY INTERVENTION SERVICES FOR CHILDREN

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

The Company shall reimburse certified Early Intervention providers, who are designated as such by the Department of Human Services, for Early Intervention Services at rates of reimbursement equal to or greater than the prevailing integrated state/Medicaid rate for Early Intervention Services as established by the Department of Human Services.
"Early Intervention Services" means, but is not limited to, speech language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for Dependents from birth to age three (3) who are certified by the Department of Human Services as eligible for services under part C of the Individuals with Disabilities Education Act (20 U.S.C. sec. 1471 et seq.).

BENEFITS FOR HEARING AIDS

Benefits will be paid up to $1,500 per individual hearing aid, per ear, every three (3) years for an Insured Person under age nineteen (19); and will be paid up to $700 per individual hearing aid, per ear, every three (3) years for an Insured Person over age nineteen (19). Hearing aid means any non- experimental wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including but not limited to FM devices.

BENEFITS FOR HUMAN LEUKOCYTE ANTIGEN OR HISTOCOMPATIBILITY LOCUS ANTIGEN TESTING

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

BENEFITS FOR THE TREATMENT OF INFERTILITY

Benefits will be paid the same as any other Sickness with a lifetime maximum of $100,000 for the medically necessary expenses of diagnosis and treatment of Infertility. The insured co-payment shall not exceed 20% for those programs and/or procedures of the sole purpose of which is the treatment of infertility. "Infertility" means the condition of an otherwise presumably healthy married individual who is between age 25 and 42 unable to conceive or sustain a pregnancy during a period of one (1) year.

BENEFITS FOR SCREENING FOR LEAD POISONING

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

BENEFITS FOR TREATMENT OF LYME DISEASE

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

BENEFITS FOR MAMMOGRAPHY AND PAP SMEAR

Benefits will be paid for mammograms and pap smears in accordance with the guidelines established by the American Cancer Society. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under this Policy. Coverage is provided for two (2) screening mammograms per year when recommended by a physician for women who have been treated for breast cancer within the last five (5) years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.

Reimbursement for mammograms will be made only if the facility in which the mammogram has been taken and processed and the licensed Physician interpreting the mammogram both meet state-approved quality assurance standards for taking, processing, and interpreting mammograms. Reimbursement for pap smears will be made only if the laboratory in which the pap smear is processed is licensed by the Rhode Island Department of Health specifically to perform cervical cytology, or is accredited by the American Society of Cytology, or is accredited by the College of American Pathologists, or is a Hospital accredited by The Joint Commission or the American Osteopathic Association at the time the pap smear is processed.

BENEFITS FOR MASTECTOMY, RECONSTRUCTIVE SURGERY, AND PROSTHETIC DEVICES

Benefits will be paid the same as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured for an axillary node dissection or a Mastectomy for the treatment of breast cancer. Benefits will be paid for a minimum of forty-eight (48) hours of inpatient care following a Mastectomy and a minimum of twenty-four (24) hours after an axillary node dissection. If the Insured in consultation with the Physician chooses to be discharged earlier than the time period stated for the applicable procedure, benefits will be paid for a minimum of one (1) home visit conducted by a Physician or Registered Nurse. Benefits will be paid the same as any other Sickness for reconstructive surgery performed after a Mastectomy. Benefits will be paid for Prosthetic Devices and reconstruction to produce a symmetrical appearance. Benefits will be paid for prostheses and treatment of physical complications, including lymphademas, at all stages of Mastectomy, in consultation with the attending Physician and the patient. “Mastectomy” means the removal of all or part of the breast to treat breast cancer, tumor, or mass. “Prosthetic Devices” means and includes the provision of initial and subsequent prosthetic devices ordered by the Insured’s Physician.

BENEFITS FOR TREATMENT OF MENTAL ILLNESS AND SUBSTANCE ABUSE

Benefits will be paid the same as any other Sickness for the treatment of Mental Illness and Substance Abuse. Benefits will include inpatient hospitalization, partial hospitalization provided in a Hospital or any other licensed facility, intensive outpatient services, Outpatient Services, and Community Residential Care Services for Substance Abuse treatment. Benefits will not include methadone maintenance services or Community Residential Care Services for Mental Illnesses other than Substance Abuse disorders. Outpatient Services, except outpatient medication visits, will be paid for up to thirty (30) visits in any policy year. Outpatient Services for Substance Abuse treatment will be paid for up to thirty (30) hours in any policy year. Community Residential Care Services for Substance Abuse treatment will be paid for up to thirty (30) days in any policy year and detoxification benefits will be paid for up to five (5) detoxification occurrences or thirty (30) days in any policy year, whichever comes first.

Mental Illness means any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization and that substantially limits the life activities of the person with the illness, provided, however, that tobacco and caffeine are excluded from the definition of "substance" for the purposes of this Policy. Mental Illness shall not include: a) mental retardation, b) learning disorders, c) motor skills disorders, d) communication disorders, and e) mental disorders classified as "V" codes. "Outpatient Services" means office visits that provide for the treatment of Mental Illness and Substance Abuse. "Community Residential Care Services" means those facilities as defined and licensed in accordance with Rhode Island Title 40.1, Chapter 24.5.

CERTIFIED COUNSELORS IN MENTAL HEALTH

Benefits will be paid for the services of licensed counselors in mental health and licensed therapists in marriage and family practice, excluding marital and family therapy unless the individual is diagnosed with a mental disorder.

CANCER CLINICAL TRIALS BENEFITS

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

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

3. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
4. The patients receiving the investigational treatment meet all protocol requirements;
5. There is no clearly superior, non-investigational alternative to the protocol treatment;
6. The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as successful as the non-investigational alternative; and
7. The coverage of new cancer therapy treatment provided pursuant to a Phase II clinical trial will not be required for only that portion of that treatment provided as part of the phase II clinical trial; and is otherwise funded by a national agency, such as the National Cancer Institute, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical and/or pharmaceutical industry or manufacturers of medical devices. Any portions of a Phase II trial which are customarily funded by government, biotechnical and/or pharmaceutical and/or medical device industry sources in Rhode Island or in other states will continue to be so funded in Rhode Island and coverage pursuant to this section shall supplement, not supplant, customary funding.

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

BENEFITS FOR OFF-LABEL DRUG USE FOR CANCER TREATMENT

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

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

BENEFITS FOR SERVICES OF LICENSED MIDWIVES

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

BENEFITS FOR MATERNITY LENGTH OF STAY

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

BENEFITS FOR PROSTATE AND COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for prostate and colorectal examinations and laboratory tests for cancer for any non-symptomatic Insured in accordance with the current American Cancer Society guidelines.

BENEFITS FOR TOBACCO CESSATION TREATMENT

Benefits will be paid for expenses incurred for tobacco cessation treatments including 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.

Smoking cessation treatment, as used in this regulation, includes the tobacco dependence treatments identified as effective in the most recent clinical practice guideline published by the United States Department of Health and Human Services for treating tobacco use and dependence. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under this Policy.

MASTECTOMY LENGTH OF STAY BENEFIT

Benefits will be provided on the same basis as for any other Sickness for prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for a Covered Person incident to mastectomy. Reconstruction surgery under this benefit must be performed within eighteen months of the original mastectomy.

NURSE ANESTHETIST BENEFIT

Benefits are payable for the services rendered by a certified nurse anesthetist designated as a certified registered nurse anesthetist by the board of nurse registration and nursing education.

REGISTERED NURSE FIRST ASSISTANTS BENEFIT

Benefits are payable for services rendered by a licensed registered nurse first assistant designated as a registered nurse first assistant.

NON-FORMULARY MEDICATIONS BENEFIT

Benefits are payable for medications not on our formulary if, in the opinion of the Covered Person's Physician, the prescription of such non-formulary medication is Medically Necessary. This benefit is payable only when the non-formulary medication meets our medical exception criteria for the coverage of that medication.

EXCLUSIONS

Benefits will not be paid under this Policy and any attached Rider for any expenses which result from:

(1). Expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to natural teeth (or as specified in benefits);

(2). Services that are provided normally without charge by the University's Health Center, infirmary or Hospital; or by any person employed by the University;

(3). Eyeglasses, radial keratotomy, contact lenses, or prescriptions or examinations except as required for repair caused by a covered Injury;

(4). Cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment within 24 hours of the accident. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Policy;

(5). Elective Surgery or Elective Treatment;

(6). Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline. This exclusion does not apply to insured students while taking flight instructions for school credit;

(7). Declared or undeclared war, riot, civil disorder, civil commotion or acts of terrorism;

(8). Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law;

(9). Treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of other insurance;

(10). Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate contest or competition sponsored by the school, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant (Note: exclusion does not apply to club and intramural);

(11). Treatment of temporomandibular joint dysfunction (TMJ) and associated myofacial pain;

(12). Committing or attempting to commit an assault or felony; or fighting, except in self defense;

(13). Injury resulting from racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;

(14). Expenses resulting from a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the accident takes place (this exclusion will not apply to passengers if they are insured under the Policy);
(15). Hearing or speech tests to the extent that the benefits are or would have been provided under accompanying regulations governing the health of school children and the special education of handicapped children or comparable requirements established by federal law;
(16). Routine screenings or tests which are not Medically Necessary for the diagnosis or treatment of your condition or which are not specifically ordered by the admitting Physician;
(17). Personal and convenience items and completion of forms.

COORDINATION OF BENEFITS

EXPLANATION When a person is covered by more than one Plan, the benefits that are paid will be shared between the Plans. This is done so that the total benefits paid will not be more than 100 percent of the Allowable Expenses for any Covered Person.

In a Policy Year this Policy will pay:

(1) its regular benefits in full; or
(2) a reduced amount of benefits if a Covered Person is covered under more than one Plan. If a reduced amount of benefits is paid using this provision, each benefit that would be payable in the absence of this provision:
  a) will be reduced to the same proportion; and
  b) the reduced amount will be charged against any benefit limit of this Policy that applies.

EFFECT ON BENEFITS This provision will be used to determine a Covered Person's benefits for any Policy Year when the sum of the following is more than the Allowable Expenses:

(1) the benefits that would be paid under this Policy in the absence of this provision; and
(2) the benefits that would be paid under all other Plans in the absence of similar provisions whether or not a claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service given will be considered as a benefit paid.

The benefits of another Plan that co-ordinates its benefits with this Policy will be ignored in order to determine the benefits under this Policy if:

(1) another Plan provides that its benefits be paid after the benefits of this Policy; and
(2) this Policy provides that its benefits be paid before such other Plan.

ORDER OF BENEFIT DETERMINATION The Plan that pays first figures its benefits exactly as though duplicate coverage does not exist. The second Plan will pay for Allowable Expenses not covered by the first Plan if this amount is not more than the benefits payable when there is no duplicate coverage.

When two or more Plans contain non-duplication clauses, the order in which the Plans will pay benefits will be as follows:

(1) a Plan that covers the person as other than a Dependent will pay before a Plan that covers the person as a Dependent;

(2) a Plan that covers the person as a Dependent of a person whose birthday falls earlier in a year will pay before a Plan that covers the person as a Dependent of a person whose birthday falls later in that same year, except that:
   a) a Plan that covers a child as a Dependent of the parent with custody will pay before a Plan that covers the child as a Dependent of the parent without custody. This occurs when the parents are separated or divorced and the parent with custody has not remarried;
   b) a Plan that covers a child as a Dependent of the parent with custody will pay before a Plan that covers the child as a Dependent of the stepparent. A Plan that covers the child as a Dependent of the stepparent will pay before the benefits of a Plan which covers the child as a Dependent of the parent without custody. This occurs when the parents are divorced and the parent with custody has remarried;
   c) however, a Plan that covers a child as a Dependent of the parent who is financially liable will pay before any other Plan that covers the child as a Dependent child. This occurs when there is a court decree which would otherwise establish financial liability for the medical, dental or other health care expenses of the child; and

(3) the first Plan to pay when the order of payment cannot be determined by these rules will be the Plan that has covered the person for the longer period of time.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION In order to determine whether this provision applies the Company may:

(1) release or obtain any necessary information from any other organization or person with a legitimate interest;

(2) require any person claiming benefits to furnish such necessary information; and

(3) receive information reasonably related to a claim for benefits under this Plan.

FACILITY OF PAYMENT The Company has the right to make payments to any organizations when payments have been made under any other Plans and should have been made under this Policy.

Payment will be in any amount determined by the Company to be warranted. The amounts paid will be considered benefits paid and the Company will be liable only to the extent of payment made.

RIGHT OF RECOVERY The Company may recover any payments it makes in excess of the amount needed to satisfy the intent of this provision from among one or more of the following:

(1) any person that receives payments; or

(2) any other insurance companies or other organizations.

STUDENT ASSISTANCE SERVICES
(Administered by On Call International)

Nurse Helpline: On Call shall provide Students enrolled in this Plan with clinical assessment, education and general health information. This service shall be performed by a registered Nurse counselor to assist in identifying the appropriate level and source(s) of care for Students (based on symptoms reported and/or health care questions asked by or on behalf of Students). Nurses shall not diagnose a Student's ailments.

Travel Assistance Services: Each Insured Student and his/her enrolled Dependents are eligible for travel assistance services when traveling 100 miles or more away from their home and campus address. Travel Services are only available for medical claims that are covered under the College's Student Accident and Sickness Insurance Plan. Services provided include: Emergency Medical Transportation (Evacuation/Repatriation); Medical Monitoring; Medical, Dental, & Pharmacy Referrals; Deposit, Advance, & Payment Guarantees; Dispatch of Medicine, Physician, or Nurse; Return of Deceased Remains; Return of Minor Children Assistance; Pre-Trip Information; 24/7 Emergency Travel Arrangements; Translation Assistance; Emergency Travel Funds Assistance; Worldwide Legal Assistance; Lost/Stolen Travel Documents Assistance; Emergency Message Forwarding; and Lost Luggage Assistance.

Bedside Visit: In the event that a covered student will be hospitalized 7 days or longer, On Call International will provide a benefit of up to $2,500 for a parent or family member to join the hospitalized student. The benefit can go towards transportation and accommodations. In all cases On Call International must make and pay for the travel and accommodations arrangements. There is no reimbursement for transportation or accommodations if made by the family or school.

Emergency Return Home: If a parent or sibling of a covered student dies or is hospitalized for a life threatening illness while the student is away at school (100 miles or more), On Call International will provide a benefit of up to $2,500 for the student to return home. In all cases On Call International must make and pay for the travel arrangements. There is no reimbursement for transportation if made by the student, family or school.

U.S. & Canada Toll Free: 866-525-1955/ International Collect: 603-328-1955

Note: The On Call related services listed above are not insurance and are not connected with or provided by Monumental Life Insurance Company

QUESTIONS? NEED MORE INFORMATION?

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

Bollinger
Insurance Solutions

101 JFK Parkway • Short Hills, NJ 07078
Telephone 800-526-1379
www.BollingerColleges.com/URI

CLAIM PROCEDURE

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

1. Physicians and hospitals may submit itemized bills directly to Bollinger, Inc. electronically using BOLL1 or mailing them to the address below for Bollinger.
2. Notify Bollinger, Inc. within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible. Complete the Bollinger claim form in full and sign it. Written proof of loss must be given within 90 days after the date of the loss. Mail a copy to Bollinger, Inc, P.O. Box 727, Short Hills, NJ 07078-0727.
3. Claim forms are available online at www.BollingerColleges.com/URI or by calling 866-267-0092. If the providers have given you bills, please keep a copy and attach them to the claim form.
4. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to Bollinger, Inc. Online claim status is available at www.BollingerColleges.com/URI or by calling 866-267-0092.
5. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills received after the initial claim form has been submitted should be mailed promptly to Bollinger.

Appeal Process: Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person must request an appeal in writing within 90 days of the date appearing on the EOB. The appeal request must include any additional information to support the request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator at the address below.

Claims Administrator:
BOLLINGER, INC.
P.O. BOX 727• Short Hills, NJ 07078-0727
866-267-0092

NOTE: PLEASE KEEP THIS BROCHURE AS A GENERAL SUMMARY OF THE INSURANCE BENEFITS. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. If any discrepancy exists between the Brochure and the Master Policy, the Master Policy will govern and control the payment of benefits.

Policy#:CRI203J
Policy Form: SH1000GPM(rev.2000).RI 26100910