Dear Student:

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

STUDENT HEALTH INSURANCE PLAN

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

ELIGIBILITY

All full-time students at Bryant University are eligible to enroll in this Insurance Plan. All International Students and Athletes will be automatically enrolled in the health insurance but have the option to waive the insurance if they have proof of comparable coverage.

BRYANT UNIVERSITY

2016-2017

Underwritten by:
National Guardian Life Insurance Company
Madison, WI
Policy Number: 2016I5A66

Administered by:
CHP Student
Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

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

16-I5A66 (Bro.)

ONLINE WAIVER PROCESS

The online Waiver process is the only accepted process for making your insurance selection. The deadline for processing the online waiver is August 1, 2016 for students enrolling in the fall term and February 1, 2017 for students newly enrolling in the spring term. Students who waive the Student Health Insurance Plan in the fall, waive coverage for the entire policy year. To document proof of comparable coverage, students need to complete the online waiver and submit it by the deadline date. To complete the online waiver, log on to the Bryant portal at https://my.bryant.edu, click on the Banner icon, choose Student Services and Financial Aid, then Health and Medical Forms and complete the “Health Insurance Information” form. If you waive the school health plan, you must provide Health Services with proof of your own health insurance by submitting a copy of the front and back of your insurance card.

ATHLETES/INTERNATIONAL STUDENT WAIVER PROCESS

All Athletes and International Students will automatically be enrolled and billed $2,402 for the Student Health Insurance Plan unless they waive the insurance plan and also provide proof of comparable coverage in another health insurance plan (preferably in the United States that will be in effect from August, 2016 through August, 2017). If you have your own health insurance, you must provide proof of the alternative insurance to Health Services by August 1, 2016 by logging into https://my.bryant.edu, click on the Medicat icon, then Required Forms, and then finally Insurance Entry. Please input your insurance information and click on the Insurance Waiver link to waive the student health insurance. Once you complete the health insurance information and submit it online, the charge will be removed from your Bryant student account if the alternative insurance is acceptable. If you are waiving the plan, please provide a copy of the front and back of your insurance card to Health Services as proof of health insurance.
Bryant University reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Health Insurance Plan, effective the date that the determination was made and there will be no pro-rata refund of premium.

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

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

“Dependent” means: 1) An Insured Student’s lawful spouse or lawful Domestic Partner; 2) An Insured Student’s dependent biological or adopted child or stepchild under age 26; and 3) An Insured Student’s unmarried biological or adopted child or stepchild who has reached age 26 and who is: a. Primarily dependent upon the Insured Student for support and maintenance; and b. Incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap. Proof of the child’s incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

Newly Born Children - A newly born child of an Insured Person will be covered from birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. To continue coverage beyond this initial 31-day period, the Insured Person must: 1. Notify Us of the birth; and 2. Pay any added premium.

DEPENDENT ENROLLMENT
There are two ways to submit dependent enrollment information. You may request a Dependent Enrollment form by contacting University Health Plans at 800-437-6448, or you may submit an Online Dependent Enrollment Form. To submit dependent information online, go to www.universityhealthplans.com.
Payment for dependent coverage is in addition to the fee for student coverage. New or previously insured Dependents must be enrolled by September 15, 2016 for annual coverage or February 25, 2017 for spring semester for new students to Bryant University. If the deadline for enrolling an eligible dependent is not met, the dependent cannot be added until the following school term. The deadline to add eligible dependents due to a qualifying event (i.e. birth, marriage, loss of coverage), is thirty-one (31) days from the qualifying event in order to avoid a break in continuous coverage. If the deadline is not met, the effective date will be the postmark date on the envelope or the date the online Dependent Enrollment form is submitted.

EFFECTIVE AND TERMINATION DATES
The Master Policy on file at the school becomes effective on August 15, 2016. Coverage becomes effective on that date or the date the enrollment form and premium are received by the Company, whichever is later. For International Students or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be no more than 48 hours later than the departure from the Home Country. The Master Policy terminates on August 14, 2017. For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks); or for International Students, the date the student ceases to meet Visa requirements.
Coverage terminates on that date or the end of the period for which premium is paid, whichever is earlier.

### PLAN COSTS

<table>
<thead>
<tr>
<th></th>
<th>Annual*</th>
<th>Spring Term*</th>
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<tbody>
<tr>
<td>Student</td>
<td>$2,402</td>
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<tr>
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<tr>
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<tr>
<td>3 or more Dependents</td>
<td>$7,206</td>
<td>$4,185</td>
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*The above rates include an administrative fee.

REFUND OF PREMIUM
Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:
1. For any student who does not attend school during the first thirty-one (31) days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the premium minus the cost of any benefits paid by Us will be made. Coverage for Insured students who withdraw for any reason after the first 31 days will continue through the end of the Policy Term. No refund will be made available.
2. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his or her entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.
3. For International Students, Scholars, Visiting Faculty member and/or their covered Dependents. We will refund a pro rata portion of the premium actually paid for any individual who:
   a. Withdraws from School during his/her first semester; and
   b. Returns to his/her Home Country.
A written request must be sent to us within 60 days of such departure
No other refunds will be allowed.

PREFERRED PROVIDER NETWORK
The Bryant University Student Health Insurance Plan provides access to hospitals and health care providers, who participate in Preferred Provider Networks, both
locally and across the country. The advantage to using Preferred Providers is that these providers have agreed to accept a predetermined fee or PPO Allowance as payment in full for their services. Consequently, when Insured Persons use Preferred Providers, out-of-pocket expenses may be less because any applicable coinsurance will be based on a PPO Allowance.

The Insured Person should be aware that Preferred Provider Hospitals might be staffed with Out of Network Providers. As a result, receiving services or care from an Out of Network Provider at a Preferred Provider Hospital does not guarantee that all charges will be paid at the Preferred Provider level of benefits. The participation of specific providers in the Preferred Provider Networks is subject to change without notice. Insured Persons should always confirm when making an appointment that the provider participates in a Preferred Provider Network.

**First Health Network** is the Preferred Provider Network and provides access to providers located across the United States. To determine if a provider participates in First Health, students can visit www.firsthealthlpb.com. It is important that Insured Persons verify that their providers are Preferred Providers each time they call for an appointment or at the time of service.

Preferred Providers are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. PPO Allowance is the amount a Preferred Provider will accept as payment in full for covered medical expenses. Out of Network refers to a provider who has not agreed to any prearranged fee schedules. We will not pay charges in excess of the Usual & Customary (U&C) Charges. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are Insured’s responsibility.

**PRESCRIPTION DRUG BENEFIT**

The Prescription Program is available through the Catamaran Pharmacy Network. After a $10 co-payment for a 30-day supply of a generic drug, ($0 co-pay for a 30-day supply of a generic Contraceptive) and a $20 co-payment for a 30-day supply of a brand name drug. Insured Persons will be given an ID card to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving the ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained from Consolidated Health Plans.) To locate a participating Catamaran Pharmacy, please call Consolidated Health Plans at (800) 633-7867. Not all medications are covered.

**DEFINITIONS**

**Accident** means a sudden, unforeseeable external event that causes Injury to an Insured Person. The Accident must occur while coverage is in effect for the Insured Person.

**Covered Injury** means a bodily injury that is:
1. Sustained by an Insured Person while he or 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:
1. From the date of Injury; and
2. Until the date services or supplies are received, for them to be considered as a Covered Medical Expense under this Policy.

**Covered Medical Expense** means those charges for any treatment, service or supplies that are:
1. Not in excess of the Usual and Reasonable charges therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the PPO Allowance; and
4. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

**Covered Sickness** means Sickness, disease or trauma related disorder due to Injury which:
1. causes a loss while the Policy is in force; and
2. which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

**Insured Student** means a student of the Policyholder who is eligible and insured for coverage under this Policy.

**International Student** means an international student:
1. With a current passport and a student Visa;
2. Who for the time being resides outside of his or her Home Country; and
3. Is actively engaged, on a full time basis, as a student or in educational research activities through the Policyholder.

In so far as this Policy is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

**Physician** means a: Doctor of Chiropractic (D.C.), Doctor of Dentistry (D.M.D. or D.D.S.), Doctor of Medicine (M.D.), Doctor of Optometry (O.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatry (D.P.M.) who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered.

A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

**Physician** will also means any licensed practitioner of the healing arts who We are required by law to recognize as a “Physician.” This includes an acupuncturist, a certified nurse practitioner, a certified nurse midwife, a Physician’s assistant and social workers. This also includes psychiatric nurses to the extent that their services would be covered if performed by a Physician.

The term Physician does not mean any person who is an Immediate Family Member.

**Hospital** means an institution that:
1. Operates as a Hospital pursuant to law;
2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
3. Provides 24-hour nursing service by Registered Nurses on duty or call;
4. Has a staff of one or more Physicians available at all times; and
5. Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis.

Hospital does not include the following:
1. Convalescent homes or convalescent, rest or nursing facilities;
2. Facilities primarily affording custodial, educational, or rehab care; or
3. Facilities for the aged.

Essential Health Benefits mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Emergency Medical Condition means a medical condition which:
1. manifests itself by acute symptoms of sufficient severity (including severe pain); and
2. causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention might result in:
   a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily functions; or
   c. Serious dysfunction of any bodily organ or part.

Emergency Services means transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

Medically Necessary means medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice. The Insured Person’s health care provider determines if the medical treatment provided is medically necessary.

Mental Health Disorder means a condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Mental Health Disorders must be listed in the most recent version 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.

Substance Use Disorder means any condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version 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.

Usual and Reasonable means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a:
1. Like service by a provider with similar training or experience; or
2. Supply that is identical or substantially equivalent.

Visa, in so far as this Policy is concerned, means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid visa, either an F-1 (Academic), J-1 (Exchange) or M-1(Vocational) in order to continue as a student in the United States.

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

STATE MANDATED BENEFITS

Mandate Disclaimer: If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

Infertility Treatment for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years. Infertility treatment includes assistive reproductive technologies such as in-vitro fertilization. Benefits are not payable for an Insured who has previously undergone a voluntary sterilization procedure.

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

Contraceptive Coverage for F.D.A.-approved contraceptive drugs and devices which require a prescription on the same basis as other Prescription Drugs. We will not pay for the prescription Drug RU 486.

Mastectomy Treatment and Hospital Stay for expenses incurred by an Insured Person for not less than forty-eight (48) hours of inpatient care following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer. Coverage is included for expenses incurred for reconstructive breast surgery performed as a result of a partial or total mastectomy as described in the Inpatient Surgery benefit. Any such reconstructive breast surgery includes coverage for reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed. The reconstructive surgery and any adjustments made to the non-diseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast. Benefits will be paid for prostheses and treatment of physical complications, including lymphademas, at all stages of mastectomy, in
consultation with the attending Physician and the patient.

Hair Prosthesis (Wigs) for incurred expenses for a scalp hair prosthesis (wig) worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. Coverage is limited to $350 per hair prosthesis (wig) per Policy Year.

Hearing Aids for audiological services and hearing aids for Insured Persons as described in the Schedule of Benefits.

Pediatric Preventive Care/Screening/Immunization for expenses incurred for eligible participants who are Dependents of an Insured Student, from birth through the date the child is eighteen (18) years of age for:

a. Immunization against diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, haemophilus influenzae type B, and hepatitis A; and

b. Any other immunization subsequently required for children by the Rhode Island Department of Health. Benefits will not be provided for pediatric preventive care services that are paid for or offered free of charge by the state of Rhode Island. Biologicals used for vaccinations are covered by the state of Rhode Island.

Smoking Cessation Programs for expenses incurred for tobacco cessation treatments. This includes outpatient counseling for smoking cessation when provided by a qualified practitioner and nicotine replacement therapy or prescription drugs. Nicotine replacement therapy includes, but is not limited to nicotine gum, patches lozenges, nasal spray and inhalers.

Smoking cessation treatment includes the use of an over-the-counter (OTC) or prescription FDA smoking cessation medication, when used in accordance with FDA approval, for not more than two (2) courses of medication of up to fourteen (14) weeks each, annually, when prescribed by a qualified practitioner, and used in combination with smoking cessation counseling sessions provided by a qualified practitioner.

Lead Poisoning for expenses incurred for screening for lead poisoning and lead screening related services for children under six (6) years of age. Coverage includes diagnostic evaluations for lead poisoning. This includes but is not limited to confirmatory blood lead testing.

Lyme Disease Treatment for expenses incurred for diagnostic testing and long-term antibiotic treatment of chronic Lyme disease when determined to be Medically Necessary and ordered by a Physician after making a thorough evaluation of the patient’s symptoms, diagnostic test results and response to treatment. Treatment shall not be denied solely because such treatment may be characterized as unproven, experimental, or investigational in nature.

Diabetes Benefit for expenses incurred for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when Medically Necessary and when recommended or prescribed by a Physician:

a. Blood glucose monitors,

b. Blood glucose monitors to the legally blind,

c. Test strips for glucose monitors,

d. Visual reading and urine testing strips,

e. Insulin,

f. Injection aids,

g. Cartridges for the legally blind,

h. Syringes,

i. Insulin pumps and appurtenances thereto,

j. Insulin infusion devices,

k. Oral agents for controlling blood sugar, and

l. Therapeutic/molded shoes for the prevention of amputation,

m. Prosthetic devices, up to $350 per year.

When Medically Necessary, this benefit includes coverage for:

a. Self-management and treatment of the Insured Person’s diabetes. The self-management must be supervised by a Physician or an appropriately licensed, registered, or certified health care professional as part of an office visit for diabetes diagnosis or treatment. Such training may be provided in group settings when practical.

b. Physician visits relating to medical nutrition therapy:

1) Upon the diagnosis of diabetes;

2) A Physician diagnosis which shows a significant change in the patient’s symptoms or conditions which require changes in a patient’s self-management; and

3) When reeducation or refresher training is necessary.

Medical nutrition therapy education must be provided by the Physician or an appropriately licensed and certified health care provider. Such education may be conducted in group settings.

Coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when Medically Necessary.

c. Podiatric health care provider services to prevent complications from diabetes.

Early Intervention Services for expenses incurred for early intervention services for dependent children up to Age 3. This coverage is limited to five thousand dollars ($5,000) per dependent child.

As used in this benefit:

“Early Intervention Services” means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review. It also means nursing services, and assistive technology services and devices for dependents from birth to age three (3) who are certified by the department of human services as eligible for services under part C of the Individuals with Disabilities Education Act (20 U.S.C. Section 1471 et seq.).

Enteral Nutrition Products for non-prescription enteral formulas for home use for which a Physician has issued a written order and which are Medically Necessary for the treatment of malabsorption caused by Crohn’s disease, ulcerative colitis, gastro esophageal reflux, chronic intestinal pseudo-obstruction, and inherited diseases of amino and organic acids. Coverage for inherited diseases of amino and organic acids includes food products modified to be low protein. When enteral formula is delivered through a feeding tube, we will pay the expense incurred when it is the sole source of nutrition.

Human Leukocyte Antigen Testing Benefit for expenses incurred for testing for utilization in bone marrow transplantation. The human leukocyte antigen testing, also known as histocompatibility locus antigen testing, for A, B, and DR antigens must be performed in a facility that is accredited by the American Association of Blood Banks or its successors, and is licensed under the
Clinical Laboratory Improvement Act, 42 U.S.C. § 263a. 

**Mammogram and Pap Smear Benefit** for expenses incurred for Mammograms and Pap Smears. The mammogram and pap smear must be recommended by a Physician for an Insured Person who has been treated for breast cancer within the last 5 years on the same basis as other Preventive Services.

**Prostate and Colorectal Examination Benefit** for prostate and colorectal examinations and laboratory tests to detect cancer in any non-symptomatic Insured Person in accordance with current American Cancer Society guidelines.

**Approved Clinical Trial Benefit** for expenses incurred in relation to a clinical trial. We will not deny or limit or impose additional conditions on benefits for routine patient costs for items or services furnished to the Insured Person in connection with his or her participation in the Approved Clinical Trial.

As used in this benefit:

**Approved Clinical Trial** means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to prevention, detection, or treatment of cancer or a life-threatening disease or condition and is described in any of the following:

a. A study approved or funded by one or more of the following: federal National Institutes of Health (NIH); federal Centers for Disease Control and Prevention (CDC); federal Agency for Health Care Research and Quality (AHRQ); federal Centers for Medicare & Medicaid Services (CMS); a cooperative group or center of any of the entities described above or the U.S. Department of Defense or the U.S. Department of Veteran Affairs; a qualified non-governmental research entity identified in the guidelines by NIH for center support grants; or a study or investigation conducted by the U.S. Department of Defense or the U.S. Department of Veteran Affairs or the U.S. Department of Energy;

b. The study is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; or

c. The study is a drug trial that is exempt from having such an investigational new drug application.

**Routine Patient Costs** means items and services that are usually covered for an Insured Person who is not enrolled in an Approved Clinical Trial. Routine Patient Costs do not include the investigational item, devices, or services itself; items and services that are provided solely to satisfy data collection and analysis needs and that are not used indirect clinical management of the patient; or a service that is clearly inconsistent with widely accepted, established standards of care for a particular diagnosis.

**EXTENSION OF BENEFITS**

Coverage under this Policy ends on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended as follows: If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to 90 days from the Termination Date while such confinement continues. The Extension of Benefits will end on the earliest of the following dates: 1. Hospitalization is not Medically Necessary; or 2. The Insured Person obtains other coverage.

**COORDINATION OF BENEFITS PROVISION**

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

**EXCLUSIONS & LIMITATIONS**

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

This Policy does not cover loss nor provide benefits for any of the following. That is except as otherwise provided by the benefits of this Policy and as shown in the Schedule of Benefits.

1) **International Students Only** expenses incurred within the Insured Person’s Home Country or country of regular domicile, that exceeds the benefit amount shown in the Schedule of Benefits.

2) routine physical or other examinations where there are no objective indications of impairment of normal health. Except as specifically provided under the Policy.

3) preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.

4) loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority. Unless indicated otherwise on the Schedule of Benefits.

5) loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;

6) expenses covered under any Workers’ Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.

7) services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental injury.

8) expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as described in the Schedule of Benefits or as required for repair caused by a Covered Injury or as specifically covered under the Pediatric Vision Benefit.

9) expenses incurred for Plastic or Cosmetic Surgery. Unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.

○ For the purposes of this provision. **Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body. This can be caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to
create a normal appearance, to the extent possible.

- For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient’s appearance.

10) dental treatment including orthodontic braces and orthodontic appliances. Except as specified for accidental Injury to the Insured Person’s Sound, Natural Teeth or as specifically covered under the Pediatric Dental Benefit.

11) treatment to the teeth. This includes surgical extractions of teeth and any treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Policy definition of same. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.

12) Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.

13) weak, strained or flat feet, corns, calluses or ingrown toenails.

14) charges incurred for acupuncture in any form, Except to the extent provided in the Schedule of Benefits.

**THIRD PARTY REFUND**

When:

1. An Insured Person is injured through the negligent act or omission of another person (the “third party”); and

2. Benefits are paid under the Policy as a result of that Injury,

We are entitled to a refund by the Insured Person of all Policy benefits paid as a result of the Injury.

The refund must be made to the extent that the Insured Person receives payment for the Injury from the third party or that third party’s insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. The Insured Person must complete and return the required forms to Us upon request.

**CLAIM PROCEDURES**

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

1. Report to the nearest Doctor or Hospital and follow the prescribed treatment advice.

2. A claim form is not required to submit a claim. However, an itemized bill, (HCFA 1500, or UB04) should be used to submit expenses. The Insured Person’s name and identification number needs to be included. Providers should submit claims within ninety (90) days from the date of Accident or from the date of first medical treatment for a Sickness, or as soon as reasonably possible. If a student is submitting a claim, a copy should be retained and claims should be mailed to the Claims Administrator.

3. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to the Claims Administrator, Consolidated Health Plans.

**HOW TO FILE AN APPEAL**

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

**The Plan is Underwritten By:**

National Guardian Life Insurance Company
Madison, WI
As Policy Form NBH-280 (2016) PPO RI
Policy Number: 201615A66

National Guardian Life Insurance Company is not affiliated with Guardian Life Insurance Company of America aka The Guardian or Guardian Life.

**Claims Administrator:**

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

**Servicing Broker:**

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

For a copy of the Company’s privacy notice you may go to:
www.consolidatedhealthplan.com/about/hipaa
Or
Request one from the Health Office at your School
Or
Request one from:
National Guardian Life Insurance Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502
(please indicate the school you attend with your written request)

**Representations of this plan must be approved by the Company.**

This is not the Policy. Rather, it is a brief description of the benefits and other provisions of the Policy. The Policy is governed by the laws and regulations of the state in which it is issued and is subject to any necessary State approvals. Any provisions of the Policy, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state’s laws, including those relating to mandated benefits.
VALUE ADDED SERVICES
The following services are not part of the Plan Underwritten by National Guardian Life Insurance Company. These value added options are provided by Consolidated Health Plans.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE
Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867. If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 or if you are in a foreign country, call collect at: 715.295.9311. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. 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.

VISION DISCOUNT PROGRAM
For Vision Discount Benefits please go to: www.chpstudent.com
## BRYANT UNIVERSITY 2016-2017 SCHEDULE of MEDICAL EXPENSE BENEFITS

<table>
<thead>
<tr>
<th>Maximum Benefit</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy Year Deductible</strong></td>
<td><strong>N/A</strong></td>
</tr>
<tr>
<td><strong>Out of Pocket Maximum</strong></td>
<td><strong>$6,350 per Individual</strong> $12,700 per Family</td>
</tr>
</tbody>
</table>

### INPATIENT BENEFITS

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Room &amp; Board Expenses</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of Usual &amp; Reasonable (U&amp;R)</td>
</tr>
<tr>
<td><strong>Hospital Intensive Care Unit Expense</strong> - in lieu of normal Hospital Room &amp; Board Expenses</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Hospital Miscellaneous Expenses</strong> for services &amp; supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts &amp; temporary surgical appliances, oxygen, blood &amp; plasma, misc. supplies</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Preadmission Testing</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Physician’s Visits while Confined</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Inpatient Surgery:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Registered Nurse Services for private duty nursing while confined</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Physical Therapy (inpatient)</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Benefit</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Expense Benefit</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Mental Health Disorder</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Substance Use Disorder</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
</tbody>
</table>

### OUTPATIENT BENEFITS

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Surgery:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services &amp; supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood &amp; plasma</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>Rehabilitation Therapy</strong> including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of U&amp;R Copayment $15</td>
</tr>
<tr>
<td><strong>Habiltative Services</strong> are covered to the extent that they are Medically Necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services Expenses</strong></td>
<td>90% of PPO Allowance</td>
<td>90% of PPO Allowance for Covered Medical Expenses Copayment $100 Copayment waived if admitted</td>
</tr>
<tr>
<td>Copayment $100 Copayment waived if admitted</td>
<td>Copayment waived if admitted</td>
<td></td>
</tr>
<tr>
<td><strong>In Office Physician’s Visits</strong></td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses Copayment $15</td>
</tr>
<tr>
<td>includes care by Primary Physician, specialist, and any other licensed practitioner operating within the scope of his or her license</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Centers or Facilities</strong></td>
<td>90% of PPO Allowance</td>
<td>90% of PPO Allowance for Covered Medical Expenses Copayment $100 Copayment waived if admitted</td>
</tr>
<tr>
<td>Copayment $100 Copayment waived if admitted</td>
<td>Copayment waived if admitted</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>PPO Allowance Coverage</td>
<td>U&amp;R Coverage Coverage</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray Services</strong></td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Laboratory Procedures (Outpatient)</strong></td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>100% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td></td>
<td>Generic Copayment: $10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brand Copayment: $20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See Prescription Card</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Copays apply to a 30-day supply</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Miscellaneous Expense</strong> for services not otherwise covered but excluding surgery</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Home Health Care Expenses</strong></td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Hospice Care Coverage</strong></td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Mental Health Disorder</strong></td>
<td>100% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td></td>
<td>Copayment $15</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Use Disorder</strong></td>
<td>100% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td></td>
<td>Copayment $15</td>
<td></td>
</tr>
<tr>
<td><strong>OTHER BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Service</strong></td>
<td>100% of PPO Allowance</td>
<td>100% of U&amp;R</td>
</tr>
<tr>
<td>Insured Person’s copayment will not exceed $50 per ambulance trip</td>
<td>Copayment $50</td>
<td></td>
</tr>
<tr>
<td><strong>Braces and Appliances</strong> including Prosthesis and Orthotics</td>
<td>100% of PPO Allowance</td>
<td>100% of U&amp;R</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>100% of PPO Allowance</td>
<td>100% of U&amp;R</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity Benefit</strong></td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>including birthing center services and Complications of Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Newborn Care</strong></td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consultant Physician Services</strong> – when requested by the attending physician</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Accidental Injury Dental Treatment</strong></td>
<td>100% of PPO Allowance</td>
<td>100% of U&amp;R</td>
</tr>
<tr>
<td>Subject to $350 per tooth maximum per $1,000 Policy Year</td>
<td>Copayment for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td><strong>Sickness Dental Expense</strong></td>
<td>100% of PPO Allowance</td>
<td>100% of U&amp;R</td>
</tr>
<tr>
<td>Subject to $100 per tooth maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment outside of the U.S.</strong></td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td><strong>Sports Accident Expense</strong> - incurred as the result of the play or practice of Intercollegiate sports</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage Details</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Abortion Expense</td>
<td>Subject to $350 maximum per Policy Year for Non-Network</td>
<td></td>
</tr>
<tr>
<td>Preventive Care, Screening, and Immunizations</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td>Medical Evacuation Expense</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td>Repatriation Expense</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td>Pediatric Dental Care Benefit</td>
<td>Preventive Dental Care - limited to 1 dental exam every 6 months</td>
<td></td>
</tr>
<tr>
<td>The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:</td>
<td>50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable</td>
<td></td>
</tr>
<tr>
<td>Pediatric Vision Care Benefit</td>
<td>Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames</td>
<td></td>
</tr>
<tr>
<td>Routine Eye Care (adult)</td>
<td>Limited to 1 routine eye exam per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>100% of PPO Allowance for Covered Medical Expenses Copayment $15</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Abortion Expense: Subject to $350 maximum per Policy Year for Non-Network.
- Preventive Care, Screening, and Immunizations: 100% of PPO Allowance for Covered Medical Expenses.
- Medical Evacuation Expense: 100% of Usual and Reasonable Charge for Covered Medical Expenses.
- Repatriation Expense: 100% of Usual and Reasonable Charge for Covered Medical Expenses.
- Pediatric Dental Care Benefit: Preventive Dental Care - limited to 1 dental exam every 6 months.
- Pediatric Vision Care Benefit: Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames.
- Routine Eye Care (adult): Limited to 1 routine eye exam per Policy Year.
- Chiropractic Care: 100% of PPO Allowance for Covered Medical Expenses Copayment $15.