Dear Student:

Bryant University provides access to a Student Accident and Sickness 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 ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Student Accident and Sickness Insurance Plan available for the students of Bryant University. Security Mutual Life Insurance Company of New York 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 will be automatically enrolled in the health insurance but have the option to waive the insurance if they have proof of comparable coverage. Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased.

The Company maintains its right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

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 31, 2010 for students enrolling in the fall term and February 1, 2011 for students newly enrolling in the spring term. Students who waive the Student Accident and Sickness 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 Form and submit it by the deadline date. Go to www.universityhealthplans.com and click on Bryant University and then select the Student Accident and Sickness Insurance Plan to submit the online Waiver Form.

In addition to waiving the Student Insurance Plan, all freshman and transfer students must submit proof of health insurance to Health Services. Please fax to 401-232-6702 or mail a copy of the front and back of your insurance card to the Health Services Office by August 31, 2010.
INTERNATIONAL STUDENT WAIVER PROCESS

Eligible International Students who do not want to enroll in the Student Accident and Sickness Insurance Plan can waive coverage if they can document proof of comparable coverage in another health insurance plan, preferably in the United States, that will be in effect from 12:01 a.m. on August 15, 2010 through 12:01 a.m. on August 15, 2011. To document proof of comparable coverage, students need to show proof of the alternative insurance to the Bryant Bursar’s office by August 31, 2010. You may fax a copy of your insurance card to 1-401-232-6284. Students who do not provide proof of comparable insurance by the deadline date will be automatically enrolled in the Student Accident and Sickness Insurance Plan.

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 Accident and Sickness Insurance Plan, effective the date that the determination was made and there will be no pro-rata of premium.

QUALIFYING EVENT ENROLLMENT

In the event a student waives the Student Accident and Sickness 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 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage. Petitions received after the 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 Accident and Sickness Insurance Plan may enroll their eligible Dependents (as defined) at an additional cost. “Dependent” means: (a) the Insured Student’s spouse or domestic partner residing with the Insured Student; or (b) the Insured Student’s unmarried children under the age of twenty (20), (c) the Insured Student’s unmarried children under the age of twenty-five (25) if full-time student at an accredited institution of higher learning, (d) an unmarried child of any age who is financially dependent upon the parent and medically determined to have a physical or mental impairment that can be expected to result in death or that has lasted or is expected to last for a continuous period of not less than twelve (12) months. Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, we cover the newborn child, for dependent benefits from and after the moment of birth, or any child placed with the Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption.

To continue the dependent child’s coverage past the first 31 days, or to obtain any other dependent coverage, the Insured Student must complete and submit the Dependent Enrollment Form within 31 days of the child’s birth or date of placement for adoption or date of marriage.

The term “children” includes the Insured Student’s biological children; step-children; and adopted children from the date of placement in the Insured Student’s home.

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, 2010 for annual coverage or February 25, 2011 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 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. An Insured Person who has a break in continuous coverage will not be covered for Pre-existing Conditions that originated before or during such break except as otherwise may be provided for.
EFFECTIVE AND TERMINATION DATES
The Master Policy on file at the school becomes effective on August 15, 2010. Coverage becomes effective on that date or the date the enrollment form and premium are received by the Company, whichever is later. The Master Policy terminates on August 14, 2011. Coverage terminates on that date or the end of the period for which premium is paid, whichever is earlier.

PLAN COSTS

<table>
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PREMIUM REFUND POLICY
Except for a withdrawal due to an Injury or Sickness, any Insured Student withdrawing from the University during the first 31 days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of the premium will be made. Insured Students withdrawing after 31 days will remain covered under the Plan for the full period for which the premium has been paid and no refund will be made available. This is true for students on leave for medical or academic reasons, graduating students, and students electing to enroll in a separate comparable plan during the policy year. Premiums received by the Company are fully earned upon receipt and are non-refundable except as specifically provided. Coverage for an Insured Student entering the Armed Forces of any country will terminate as of the date of such entry. Those Insured Students withdrawing from the school to enter military service will be entitled to a pro-rated refund of premium upon written request.

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 Preferred Allowance as payment in full for their services. Consequently, when Insured Persons use Preferred Providers, out-of-pocket expenses will be less 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 (800) 226-5116 or visit www.firsthealth.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.

PRESCRIPTION DRUG BENEFIT
The Prescription Program is available through the Express Scripts Pharmacy Network. After a $10 co-payment for a 30-day supply of a generic drug and a $20 co-payment for a 30-day supply of a brand name drug, a prescription will be paid at 100% up to a maximum of $1,200 per Policy Year. Insured Persons will be given an ID to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving the ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained from Consolidated Health Plans.) To locate a participating Express Scripts Pharmacy, please call Consolidated Health Plans at 1-800-633-7867 or visit Express Scripts website at www.express-scripts.com. Not all medications are covered, for example vitamins or food supplements, drugs to promote hair growth or weight loss, immunizations, and experimental drugs are not covered.

DEFINITIONS
Accident means a specific unforeseen event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for covered medical expenses.

“Out of Network” providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are Insured’s responsibility.
Covered Injury means a bodily Injury that is:
1. sustained by an Insured Person while he/she is insured under this Policy or the School’s prior policies; and
2. caused by an Accident directly and independently of all other causes.
Coverage under the School’s policies must have remained continuously in force from the date of Injury until the date services or supplies are received for them to be considered as a Covered Medical Expense under the Policy. All Injuries sustained by one (1) person in any one (1) Accident, including all related conditions and recurrent symptoms of these Injuries are considered a single Covered Injury.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which causes a Loss while the Policy is in force and which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. Sickness includes complications of pregnancy. Sickness will also include normal pregnancy when conception occurs during the term coverage.

Insured Person means an Insured Student and his or her covered Dependent(s) while insured under this Plan.

Physician means:
1. A Doctor of Medicine (M.D.); or
2. A Doctor of Osteopathy (D.O.); or
3. A Doctor of Dentistry (D.M.D. or D.D.S.); or
4. A Doctor of Chiropractic (D.C.); or
5. A Doctor of Optometry (O.D.); or
6. A 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 mean any licensed practitioner of the healing arts who We are required by law to recognize as a “Physician.” This includes physician’s assistants; certified nurse practitioners, certified mental health clinical nurse specialists, certified nurse-midwives and other providers if the services are within the provider’s area of professional competence as established by education and licensure or certification and are currently reimbursed when rendered by any other licensed health care provider.

The term Physician does not mean any person who is an immediate family member.

Loss means medical expense caused by an Injury or Sickness which is covered by the Policy.

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 twenty-four (24) hour nursing service by Registered Nurses on duty or call;
4. Has a staff of one (1) 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 rehabilitary care;
3. Facilities for the aged, drug addicts or alcoholics; or
4. A military or veterans Hospital or Hospital contracted for or operated by a national government or its agency unless:
   a. The services are rendered on a Medical Emergency basis; and
   b. A legal liability exists for the charges made to the individual to the services given in the absence of insurance.

Emergency Hospitalization and/or Emergency Medical Care means Hospitalization or medical care that is provided for a Covered Injury or Covered Sickness caused by:
1. The sudden, unexpected onset of a medical condition with acute symptoms of sufficient severity and pain as to require immediate medical care; and
2. That in the absence of such care one could reasonably expect that the Insured’s health would be placed in serious jeopardy;
3. That there would be serious impairment of the Insured’s bodily functions; and/or
4. That there would be serious dysfunction of any of the Insured’s bodily organs or parts.

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

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

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

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

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

We, Us or Our means Security Mutual Life Insurance Company of New York.

MENTAL ILLNESS AND SUBSTANCE ABUSE EXPENSE BENEFIT

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

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

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

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

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

Mental Illness does not include:
1. Mental retardation;
2. Learning disorder;
3. Motor skills disorder;
4. Communication disorders; and
5. Mental disorders classified as “V” codes.

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

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

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

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

STATE MANDATED BENEFITS

State mandated benefits will be subject to all deductible, co-payment, co-insurance, limitations, or any other provision of the Policy.
**Pediatric Preventive Care Expense Benefit:** We will pay the Reasonable and Customary Expense incurred on the same basis as any other Sickness for services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a Doctor and rendered to a child from birth through age nineteen (19).

**Infertility Expense Benefit:** We shall provide coverage to the Insured Person for Medically Necessary expenses incurred for tests and procedures used in the diagnosis and treatment of Infertility. Infertility means the condition of an otherwise presumably healthy married individual between the ages of twenty-five (25) and forty-two (42) who is unable to conceive or sustain a pregnancy during a period of one (1) year. We will pay the Reasonable and Customary Expense incurred on the same basis as any other Sickness.

**Mastectomy Surgery and Rehabilitation Benefit:** The surgical procedure known as a mastectomy will be covered under the Surgery Benefit of this Section. Under this benefit, The Company will pay the expenses incurred for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the Insured Person following a covered mastectomy. As used in this benefit, prosthetic device means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the Insured Person’s Physician and surgeon.

**Mastectomy Hospital Stay Expense:** We shall provide coverage for a minimum forty-eight (48) hour time period in a hospital after the surgical procedures known as a mastectomy, and a minimum twenty-four (24) hours after an axillary node dissection.

**Diabetes Treatment Expense Benefit:** We shall provide coverage to the Insured Person for equipment and supplies that are used in the treatment of insulin treated diabetes, non-insulin treated diabetes, and gestational diabetes. We will provide coverage for the following equipment and supplies if Medically Necessary and prescribed by a Doctor: a) blood glucose monitors for the legally blind; b) test strips for glucose monitors and or visual readings; c) insulin; d) injection aids; e) cartridges for the legally blind; f) syringes; g) insulin pumps and appurtenances; h) insulin infusion devices; i) oral agents for controlling blood sugar; and j) therapeutic/molded shoes for the prevention of amputation. We shall provide coverage, when Medically Necessary and prescribed by a Doctor for the following: 1) new or improved diabetes equipment and supplies, which have been approved by the Food and Drug Administration (FDA); 2) diabetes self-management education to ensure that the Insured Person is instructed in the self-management and treatment of their diabetes; 3) coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when Medically Necessary.

**New Cancer Therapies Expense:** The Company will pay the expense incurred for new cancer therapies still under investigation under the following circumstances:

1. Treatment is provided pursuant to a Phase II, III or IV clinical trial that has been approved by the National Institute of Health in cooperation with the National Cancer Institute, community clinical oncology programs, the Food and Drug Administration in the form of an Investigational New Drug exemption, the Department of Veterans’ Affairs, or a qualified non-governmental research entity as identified in the guidelines of the National Cancer Institute Cancer Center support grants;

2. The proposed therapy has been reviewed and approved by a qualified institutional review board;

3. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise;

4. The available clinical or pre-clinical data provide a reasonable expectation that the protocol treatment will be at least as effective as the non-investigational alternative.

The Company will not pay for that portion of treatment that is provided as part of a Phase II clinical trial and is otherwise funded by a national agency, such as the National Cancer Institute, and the Veterans’ Administration, the Department of Defense, or funded by commercial organizations such as bio-technical and/or pharmaceutical industry or manufactures of medical devices.

**Mammography Expense (Payable as a Sickness Benefit Only):** The Company will pay the expenses incurred for mammography charges. We will pay the expenses incurred for mammography charges in accordance with the guidelines established by the American Cancer Society. We shall pay for two (2) screening mammograms per year when recommended by a physician for women who have been treated for breast cancer within the last five (5) years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.

**Cytological Screening Expense:** We will pay the expense incurred for cytological screening (Pap smear) in accordance with guidelines established by the American Cancer Society.
Off-Label Drug Treatments: When prescription drugs are provided as a benefit of the Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions has been met: 1) The drug is approved by the FDA; 2) The drug is prescribed for the treatment of cancer and 3) The drug has been recognized for treatment of that condition by one of the following: a) The American Medical Association Drug Evaluations; b) The Dispensing Information, Volume 1, “Drug Information for Health Care Professionals”; or c) Two (2) articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal. When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit documentation supporting compliance with these requirements.

Tobacco Cessation Treatment: We will pay the expenses incurred for Tobacco Cessation Treatments the same as any other Covered Sickness. Tobacco Cessation Treatments will include coverage for nicotine replacement therapy or prescription drugs. Nicotine replacement therapy includes but is not limited to nicotine gum, patches, lozenges, nasal spray and inhalers. Smoking Cessation Treatment includes the tobacco dependence treatments identified as effective in the most recent clinical practice guideline published by the United States Department of Health and Human Services.
Services for treating tobacco use and dependence. Smoking cessation treatment may be redefined by the Health Insurance Commissioner in accordance with the most current clinical practice guidelines sponsored by the United States Department of Health and Human Services or its component agencies.

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

Coverage for Orthotic and Prosthetic Services: The benefits provided under this provision are the same as benefits provided under federal laws (42 U.S.C. sections 1395K, 13951 and 1395M and 42 CFR 414.202, 414.210, 414.228, and 410.100 as applicable to this section). Prior authorization may be required to receive this benefit if required for other benefits. Benefits are limited to the model that adequately meets the patient’s medical needs as determined by the treating physician. Repair and replacement of an orthotic or prosthetic device is covered and subject to co-payments and deductibles, unless necessitated by misuse or loss.

Non-prescription Enteral Nutrition Products Expense: Benefits will be paid up to $2,500 per Policy Year for non-prescription enteral nutritional products which are necessary when recommended by the attending Physician for the treatment of malabsorption caused by Crohn’s disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Ambulance Services Benefit: We will pay the expenses incurred for ambulance services as outlined in the Schedule of Benefits. As used in this section the term Ground Ambulance Services shall mean services provided by an ambulance service licensed to operate in Rhode Island in accordance with Section 23-4.1-6. The term excludes air and water ambulance services and ambulance services provided outside of Rhode Island.

EXTENSION OF BENEFITS
Coverage under the Policy ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended if any Insured Person is Hospital confined for a Covered Injury or Covered Sickness on the date his or her insurance terminates. The Company will continue to pay the expenses incurred for the same Covered Injury or Sickness for up to ninety (90) days from the Termination Date while such confinement continues.

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

PRE-EXISTING CONDITIONS LIMITATION
After the first $2,000 in eligible expenses, Pre-existing conditions are not covered until the Insured Person has been: 1) Continuously Insured for a period of twelve (12) months without a Physician being consulted or a treatment or medication prescribed; or 2) Continuously Insured under prior Creditable Coverage for six (6) consecutive months. Prior coverage of less than 6 months will be credited toward satisfying the Pre-existing condition.

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

Pregnancy, including Complications of Pregnancy, maternity care and genetic disorders, shall not be considered a Pre-existing Condition under the Policy.

CONTINUOUS COVERAGE
Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under the Policy when premium payment is received either in Our School Plans Service Office or by Our Agent or the Plan Administrator within thirty (30) days, regardless of any breaks in calendar days between consecutive periods of insurance.
EXCLUSIONS & LIMITATIONS

The Plan does not cover nor provide benefits for:

1. Services normally provided without charge by the Policyholder’s student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Preventive medicines, serums, immunizations or vaccines, except as specifically provided;
3. Routine physical examinations, except as specifically provided unless prescribed by a Doctor for treatment of an Injury or Sickness;
4. Organ transplants, except as specifically provided;
5. Pre-existing Conditions as defined in this Policy in excess of $2,000;
6. Non-prescription drugs or medicines, except as specifically provided;
7. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided;
8. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with professional sports;
9. Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or mandatory no-fault benefits insurance;
10. Hearing and speech tests, except as specifically provided;
11. Cosmetic surgery, except as the result of a covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion will not apply to cosmetic surgery, which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child, which as resulted in a functional defect;
12. Correction of congenital defects, except as specifically provided;
13. Expenses incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth;
14. Expenses incurred for non-surgical treatment of TMJ dysfunction and associated myofacial pain;
15. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
16. Expenses as a result of participation in a felony;
17. Injury due to participation in a riot;
18. Injury or Sickness for which benefits are payable under Worker’s Compensation or Occupational Disease Law;
19. For services or supplies rendered by a close relative of the Insured Person or by a home health aide who is a member of your household. By “close relative” We mean an Insured Person’s spouse, children, parents, brothers and sisters;
20. Foot care only to improve comfort or appearance such as care for flat feet; subluxation; corns; calluses; routine care of toenails and the like, except for treatment of bunions, capsular, or bone surgery and infected and impacted toenails, which are covered when Medically Necessary;
21. Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;
22. Services, supplies, drugs or laboratory tests related to programs designed for the purpose of weight reduction, except for surgical treatment of morbid obesity;
23. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
24. Expenses incurred for vision therapy, radial keratotomy, eyeglasses, and contact lenses (except when required after surgery), other vision and hearing aids, except as required for repair caused by a covered Injury;
25. Elective treatment or elective surgery, except as specifically provided;
26. Accident occurring in consequence of 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 scheduled airline maintaining regular published schedules on a regularly established route;
27. Expenses incurred for: tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (except approved services related to organic dysfunctions); non-cystic acne; non-prescription birth control; submucus resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; and learning disabilities or disorders or Attention Deficit Disorder;
28. Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs except as noted, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery; Viagra or any therapeutic equivalents;
29. Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;

30. Testing, treatment or services for any condition in the absence of Sickness or Injury, except as specifically provided;

31. Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology and rolfing type services;

32. Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies.

**SUBROGATION PROVISION**

If we pay covered expenses for an accident or injury you incur as a result of any act or omission of a third party, and you later obtain recovery from the third party, you are obligated to reimburse us for the expenses paid. We may also take subrogation action directly against the third party. Our Reimbursement rights are limited by the amount you recover. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of your costs, disbursements and reasonable attorney fees. You must cooperate with and assist us in exercising our rights under this provision and do nothing to prejudice our rights.

**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 Student/Person’s name and identification number needs to be included.

3. Providers should submit claims within 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.

4. 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:**
Security Mutual Life Insurance of New York
Binghamton, NY
As Policy Form SMLBH-260 (Rev.10) (BU)
Policy Number: 2010I5A66

**Claims Administrator:**
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800-633-7867
Email: info@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.commercialtravelers.com/privacy.html

Or
Request one from the Health Office at your School
Or
Request one from:
Commercial Travelers Mutual Insurance Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502

(Please indicate the school you attend with your written request)

Representations of this plan must be approved by the Company.
EMERGENCY MEDICAL AND TRAVEL ASSISTANCE
MEDEX Assistance Corporation provides you with a comprehensive program with 24/7 emergency medical assistance including emergency evacuation and repatriation and other travel assistance services when you are 100 or more miles away from home. Your MEDEX identification card is your key to travel security.

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

If you have a medical or travel problem, simply call MEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 800-527-0218 or if you are in a foreign country, call collect at: 410-453-6330.

If the condition is an emergency, you should go immediately to the nearest physician or Hospital without delay and then contact the 24-hour Assistance Center.

VISION DISCOUNT PROGRAM
For Vision Discount Benefits please go to:
www.chpstudent.com/student_health
<table>
<thead>
<tr>
<th>Part</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Pharmacy</td>
<td>Sickness. Co-pay waived if admitted defined and rendered within 72 hours from the time of Injury or onset of Emergency Room and supplies. Treatment must be for a Medical Emergency as assistant surgeon during a surgical procedure</td>
</tr>
</tbody>
</table>

**INPATIENT BENEFITS**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Room and Board</td>
<td>90% of Preferred Allowance</td>
<td>80% of R&amp;C up to maximum of $5,000</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expense</td>
<td>90% of Preferred Allowance</td>
<td>80% of R&amp;C up to maximum of $5,000</td>
</tr>
<tr>
<td>In Hospital Doctor’s Visits Expense</td>
<td>90% of Preferred Allowance</td>
<td>80% of R&amp;C</td>
</tr>
</tbody>
</table>

**SURGICAL BENEFITS (Inpatient and Outpatient)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense Benefit</td>
<td>90% of Preferred Allowance up to maximum of $5,000 (Per Accident or Sickness)</td>
<td>80% of R&amp;C up to maximum of $5,000 (Per Accident or Sickness)</td>
</tr>
<tr>
<td>Anesthetist Expense</td>
<td>90% of Preferred Allowance (Included under Surgical Expense Benefit)</td>
<td>(Included under Surgical Expense Benefit)</td>
</tr>
<tr>
<td>Assistant Surgeon Expense</td>
<td>90% of Preferred Allowance (Included under Surgical Expense Benefit)</td>
<td>80% of R&amp;C (Included under Surgical Expense Benefit)</td>
</tr>
</tbody>
</table>

**OUTPATIENT EXPENSE BENEFITS**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Expense</td>
<td>90% of Preferred Allowance up to maximum of $3,000 (Per Accident or Sickness)</td>
<td>80% of R&amp;C up to maximum of $3,000 (Per Accident or Sickness)</td>
</tr>
<tr>
<td>Doctor’s Visits, limited to one visit per day</td>
<td>$15 co-payment per visit, then 100% of Preferred Allowance</td>
<td>$15 co-payment per visit, then 80% of R&amp;C</td>
</tr>
<tr>
<td>Emergency Room Expense</td>
<td>$100 co-pay per visit, then 90% of Preferred Allowance</td>
<td>$100 co-pay per visit, 80% of R&amp;C</td>
</tr>
<tr>
<td>Day Surgery Miscellaneous</td>
<td>90% of Preferred Allowance</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Physiotherapy Expenses</td>
<td>$15 co-payment per visit, then 100% of Preferred Allowance</td>
<td>$15 co-payment per visit, then 80% of R&amp;C</td>
</tr>
<tr>
<td>High Cost Procedure Expense</td>
<td>90% of Preferred Allowance up to a combined maximum of $3,000 per Accident or Sickness</td>
<td>80% of R&amp;C up to a combined maximum of $3,000 per Accident or Sickness</td>
</tr>
<tr>
<td>Ambulance Expense</td>
<td>100% of R&amp;C up to $150 per condition</td>
<td></td>
</tr>
</tbody>
</table>

**MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Expense</td>
<td>Paid the same as any other Sickness.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Expense</td>
<td>$15 co-payment, then 100% of Preferred Allowance</td>
<td>$15 co-payment, then 80% of R&amp;C Up to 30 hours per Policy Year</td>
</tr>
</tbody>
</table>

**ADDITIONAL BENEFITS**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Expense</td>
<td>$10 co-pay for a 30 day supply of a generic drug and a $20 co-pay for a 30 days supply of a brand name drug, up to $1,200 maximum for all conditions per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Wellness Immunization Benefits</td>
<td>80% of Covered Charges up to $300 per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Accident Dental Expense</td>
<td>R&amp;C up to $350 per tooth, up to a maximum of $1,000</td>
<td></td>
</tr>
<tr>
<td>Sickness Dental Expense</td>
<td>R&amp;C up to a maximum of $100 per tooth</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Paid the same as any other covered expense</td>
<td></td>
</tr>
<tr>
<td>Consultant Expense Benefit</td>
<td>90% of Preferred Allowance</td>
<td>80% of R&amp;C, up to $125</td>
</tr>
<tr>
<td>Voluntary Termination of Pregnancy</td>
<td>100% of Preferred Allowance</td>
<td>80% of R&amp;C, up to $350</td>
</tr>
<tr>
<td>Medical Evacuation and Repatriation of Remains</td>
<td>Covered up to $25,000</td>
<td></td>
</tr>
<tr>
<td>Intercollegiate Sports</td>
<td>Paid the same as any other Injury up to a maximum of $90,000</td>
<td></td>
</tr>
</tbody>
</table>