

**BRYANT UNIVERSITY STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN**

Underwritten by Companion Life Insurance Company, Columbia, SC

Policy No. 201115A66

**2011-12 SUMMARY OF BENEFITS CHART**

This is a Summary of benefits available through the Bryant University Student Accident and Sickness Insurance Plan. **This summary should be used in conjunction with the full plan description, including plan provisions, limitations and exclusions.** To obtain a copy of the full plan description, please go to [www.universityhealthplans.com](http://www.universityhealthplans.com) or [www.chpstudent.com](http://www.chpstudent.com). Question regarding the benefits, limitations and exclusions can be directed to University Health Plans at (800) 437-6448 or by email at [info@univhealthplans.com](mailto:info@univhealthplans.com).

**BASIC ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS**

The Plan provides benefits incurred by an Insured Person for loss due to a covered Accident or Sickness up to a Per Condition Aggregate Maximum of \$100,000. In-Network Providers are the Physicians, Hospital and other health care providers who have contracted to provide specific medical care at a Preferred Allowance. "Preferred Allowance" means the amount a Preferred Provider will accept as payment for Covered Medical Expenses. Out-of-Network Providers are providers who have not agreed to any prearranged fee schedule. When an Out-of-Network Provider is used, reduced or lower benefits will be provided. To locate a preferred provider, please visit [www.firsthealth.com](http://www.firsthealth.com). Benefits will be paid for each service as listed in the schedule below.

<b>Per Condition Aggregate Maximum Benefit</b>	<b>\$100,000</b>	
	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Deductible (Per Insured Person, Per Accident or Sickness)</b>	<b>N/A</b>	<b>\$100</b>

**INPATIENT BENEFITS**

<b>Hospital Room and Board</b> , Services include semi-private room, nursing services, and intensive care unit.	90% of Preferred Allowance	80% of Usual & Customary (U&C)
<b>Hospital Miscellaneous Expense</b> , covered medical expenses include, but are not limited to, anesthesia, operating room, laboratory tests, x-rays, oxygen tent, drugs, medicines, dressings, and other medically necessary non-room and board expenses.	90% of Preferred Allowance	80% of U&C up to maximum of \$5,000
<b>In Hospital Doctor's Visits Expense</b>	90% of Preferred Allowance	80% of U&C
<b>Pre-Admission Testing</b>	Paid under Miscellaneous Hospital Expense	
<b>Routine Newborn Care</b> , when hospital confined and routine newborn care provided immediately after birth	Paid the same as any other Sickness	
<b>Physiotherapy</b>	No Benefits	No Benefits

**SURGICAL BENEFITS (Inpatient and Outpatient)**

<b>Surgical Expense Benefit</b> , covered medical expenses for charges for surgical services performed by a licensed Physician	90% of Preferred Allowance up to maximum of \$5,000 (Per Accident or Sickness)	80% of U&C up to maximum of \$5,000 (Per Accident or Sickness)
<b>Anesthetist Expense</b> , covered medical expenses for charges of an anesthetist during a surgical procedure	90% of Preferred Allowance (Included under Surgical Expense Benefit)	80% of U&C (Included under Surgical Expense Benefit)
<b>Assistant Surgeon Expense</b> , covered medical expenses for charges of an assistant surgeon during a surgical procedure	90% of Preferred Allowance (Included under Surgical Expense Benefit)	80% of U&C (Included under Surgical Expense Benefit)

**OUTPATIENT EXPENSE BENEFITS**

<b>Outpatient Expense</b> , covered medical expenses include diagnostic x-ray & laboratory test and procedures, including STD testing, radiation therapy, chemotherapy, hospital outpatient department, chiropractic services, and injections when administered in a doctor's office and charged on the doctor's bill	90% of Preferred Allowance up to maximum of \$3,000 (Per Accident or Sickness)	80% of U&C up to maximum of \$3,000 (Per Accident or Sickness)
<b>Doctor's Visits</b> , limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy	\$15 co-payment per visit, then 100% of Preferred Allowance	\$15 co-payment per visit, then 80% of U&C
<b>Emergency Room Expense</b> , covered medical expenses include use of the Emergency Room and supplies. Treatment must be for a Medical Emergency as defined and rendered within 72 hours from the time of Injury or onset of Sickness. Co-pay waived if admitted	\$100 co-pay per visit, then 90% of Preferred Allowance	\$100 co-pay per visit, then 80% of U&C
<b>Day Surgery Miscellaneous</b> , covered medical expenses in connection with Outpatient Surgery include; operating room, laboratory tests, x-ray examinations, professional fees, anesthesia, drugs or medicines, therapeutic services and supplies	90% of Preferred Allowance	80% of U&C
<b>Physiotherapy Expenses</b> , limited to one visit per day	\$15 co-payment per visit, then 100% of Preferred Allowance	\$15 co-payment per visit, then 80% of U&C
<b>High Cost Procedure Expense</b> , Services include, but are not limited to CAT scan, MRI, Ultrasound and Laser Treatment	90% of Preferred Allowance up to a combined maximum of \$3,000 per Accident or Sickness	80% of U&C up to a combined maximum of \$3,000 per Accident or Sickness
<b>Ambulance Expense</b>	100% of U&C after a \$50 co-payment	

**MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS**

<b>Inpatient Expense</b>	Paid the same as any other Sickness.	
<b>Outpatient Expense</b>	\$15 co-payment, then 100% of Preferred Allowance Up to 30 hours per Policy Year	\$15 co-payment, then 80% of U&C Up to 30 hours per Policy Year

**ADDITIONAL BENEFITS**

<b>Prescription Drug Expense</b> , Prescriptions must be filled at an Express Scripts Participating Pharmacy	\$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	
<b>Preventive Care/Wellness Benefits</b> (includes routine physicals)	100% of U&C up to a Policy Year Maximum of \$500 (deductible and co-pay waived)	

<b>Wellness Immunization Benefits</b> , includes immunizations such as Hepatitis A&B, Diphtheria, Tetanus, Pertussis, MMR, Annual Flu Vaccine, HPV Vaccine, and Screenings, such as Cholesterol Screening and Blood Titers	80% of Covered Charges up to \$300 per Policy Year	
<b>Accident Dental Expense</b> , Injury to sound natural teeth	U&C up to \$350 per tooth, up to a maximum of \$1,000	
<b>Sickness Dental Expense</b> , for the removal of impacted wisdom teeth and dental abscesses	U&C up to a maximum of \$100 per tooth	
<b>Durable Medical Equipment</b>	100% of U&C up to a maximum of \$100	
<b>Home Health Care</b>	Paid same as any other covered expense	
<b>Consultant Expense Benefit</b>	90% of Preferred Allowance	80% of U&C, up to \$125
<b>Maternity</b>	Paid the same as any other Sickness	
<b>Voluntary Termination of Pregnancy</b>	100% of Preferred Allowance	80% of U&C, up to \$350
<b>Medical Evacuation and Repatriation of Remains</b>	Covered up to \$25,000	
<b>Intercollegiate Sports</b>	Paid the same as any other Injury up to a maximum of \$90,000	

Refer to Plan certificate for additional benefits; state mandated benefits, limitations, exclusions, and definitions. The complete Plan certificate is available at the School's Health Center, by calling University Health Plans at (800) 437-6448 or at [www.universityhealthplans.com](http://www.universityhealthplans.com).

**Mandated benefits** as required by the state of Rhode Island in which the Policy is issued include, but are not limited to: Alcoholism; Ambulance Services; Cancer Therapy; Contraceptives; Cranial Prosthetics; Diabetes; Early Intervention; Enteral Formula; Hearing Aid Coverage; Infertility Coverage; Leukocyte Testing Expense; Lyme Disease Treatment; Mammography and Pap Smear; Mastectomy Reconstruction; Maternity Length of Stay; Mental Illness; Off-Label Drugs; Orthotic and Prosthetic Services; Pediatric Preventive Care; Prostate and Colorectal Cancer Screening; Scalp Hair Prosthesis; Substance Abuse; and Tobacco Cessation and Smoking Cessation Treatments.

#### 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 of eligible expense, the Policy does not provide coverage for a Pre-Existing Condition until the Covered Person's coverage has been in force for a period of not less than 12 months. This limitation will not apply to pregnancy or coverage provided to newborn or adopted children.

The Pre-existing Conditions Limitations will be waived if: 1) the Covered Person was insured under Creditable Coverage; and 2) Such coverage was continuous to a date not more than 63 days prior to the effective date of coverage under this Policy; and 3) the Covered Person previously met the pre-existing conditions limitation of such policy.

#### EXCLUSIONS & LIMITATIONS

The Plan does not cover nor provide benefits for:

1. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of any Injury or Sickness, except as specifically provided by the Policy.
2. Immunizations, except as specifically provided in the Policy; preventive medicines or vaccines, except when required for treatment of a covered Injury or as specifically provided in the Policy.
3. War, or any act of war, whether declared or undeclared; service in the Armed Forces of any country. Loss which occurs during or as a result of committing or attempting to commit an assault, felony, or participation in a riot or insurrection, engaging in an illegal occupation.
4. Injuries arising out of playing or participating in any professional sport, contest or competition; traveling to or from such sport, contest or competition as a participant; or participation in any practice or conditioning program for such sport, contest or competition.
5. Expenses incurred for Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation.
6. Expenses in connection with services and prescriptions for eye examinations, eye refractions, eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems.
7. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of: a) a covered Injury that occurred while the Covered Person was insured; b) a covered child's congenital defect or anomaly; or c) as specifically provided for in the Policy.
8. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury.
9. Elective Surgery or Elective Treatment as defined by the Policy.
10. Foot care including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, week feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care.

#### WHERE TO FIND HELP

For questions about:	Please contact:
Enrollment Waiver of mandatory insurance charge Insurance Benefits	<b>University Health Plans</b> One Batterymarch Park, Quincy, MA 02169-7454 Local: (617) 472-5324 - Out of area: (800) 437-6448 - <a href="http://www.universityhealthplans.com">www.universityhealthplans.com</a>
Insurance Benefits Claims Processing ID Cards	<b>Consolidated Health Plans</b> 2077 Roosevelt Avenue, Springfield, MA 01104 Local: (413) 733-4540 - Out of area: (800) 633-7867 - <a href="http://www.chpstudent.com">www.chpstudent.com</a>