READ YOUR CERTIFICATE CAREFULLY

**PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS**

# 2012-2013

## Student Injury and Sickness Insurance Plan

Designed Especially for the Students of

# Anna Maria College

**Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.**

### Non-Renewable One Year Term Insurance

Coverage underwritten by HPHC Insurance Company, Inc., an affiliate of Harvard Pilgrim Health Care, Inc., and administered by UnitedHealthcare **Student**Resources.

**HPHC 12-BR-MA-PPO**

20-1560-1

## Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by HPHC Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $100,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-866-948-8472 Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

Welcome to the Harvard Pilgrim Student Health Plan. Your Plan is offered by HPHC Insurance Company ("the Company"), an affiliate of Harvard Pilgrim Health Care. The Plan is administered by UnitedHealthcare **Student**Resources, one of the leading providers of student health insurance to colleges and universities in the United States.

Your Plan is a preferred provider organization or "PPO" plan. It provides you with a higher level of coverage when you receive Covered Medical Expenses from Physicians who are part of the Plan's network of "Preferred Providers." The Plan also provides coverage when you obtain Covered Medical Expenses from Physicians who are not Preferred Providers, known as "Out-of-Network Providers." However, you will receive a lower level of coverage when you receive care from Out-of-Network Providers and you will be responsible for paying a greater portion of the cost.

Your benefits for care from Preferred Providers and Out-of-Network Providers are listed in the Schedule of Benefits in this Certificate. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits.

So that you can receive the highest level of benefits from the Plan, you should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the Plan's web site at www.gallagherkoster.com/AnnaMaria. The web site will allow you to easily search for providers by specialty and location. You may also call the Customer Service Department at 1-866-948-8472, toll free, for assistance in finding a Preferred Provider. The Customer Service Department can also send you a copy of the Plan's Provider Directory. If no Preferred Provider has the expertise needed to meet your medical needs, we will assist you in finding an appropriate Out-of-Network Provider.

Please feel free to call the Customer Service Department with any questions you may have about the Plan. The telephone number is 1-866-948-8472. You can also write us at:

HPHC Insurance Company
C/O UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025

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## Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-866-948-8472 or by visiting us at our administrator's website at www.gallagherkoster.com/AnnaMaria.

## Eligibility

All students enrolled in a degree program regardless of the number of credit hours and non degree students enrolled at least 75% of full-time are automatically enrolled in this insurance Plan at registration and the premium for coverage is added to their tuition billing.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study and correspondence courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers that the policy Eligibility requirements have not been met, its only obligation is refund of premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the insured student.

## Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m. August 10, 2012. Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m. August 09, 2013. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

There is no reduced premium payment for late enrollees, except as required by law.

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

**Refunds of premiums allowed only upon entry into the armed forces.**

It is the Insured's responsibility to obtain coverage the following year in order to maintain continuity of coverage. Insureds who have not received information regarding a subsequent plan prior to this policy's termination date should inquire regarding such coverage with Gallagher Koster.

## Premium Rates

| Undergraduate Students | Annual 08/10/12 - 08/09/13 | Spring/ Summer 01/19/13 - 08/09/13 |
|---|---|---|
| Student | $1,435 | $805 |
| Spouse | $3,675 | $2,051 |
| Each Child | $2,395 | $1,339 |

| Graduate Students | Annual 08/10/12 - 08/09/13 | Spring/ Summer 01/19/13 - 08/09/13 |
|---|---|---|
| Student | $1,691 | $947 |
| Spouse | $3,675 | $2,051 |
| Each Child | $2,395 | $1,339 |

**These premiums represent the total combined premium for the insurance plan offered by UHCSR as well as the EyeMed and Basix Dental Savings Plan by Gallagher Koster.*

## Involuntary Disenrollment Rate

The involuntary disenrollment rate for insureds in Massachusetts for HPHC Insurance Company for 2011 was 0%.

## Complaint Resolution

Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 1-866-948-8472. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

## Extension of Benefits After Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid follows provided as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

## Benefits Payable

All benefits are payable without discrimination for all Insured Persons under this plan. Benefits currently mandated by state and federal law are contained within these benefit provisions.

## Pre-Admission Notification

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission or whenever reasonably possible to provide notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

**IMPORTANT:** Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

## Online Waiver/Enrollment Process

Eligible students are automatically enrolled in and billed for the Student Injury and Sickness Insurance Plan. Students who are currently enrolled in a health insurance plan of comparable coverage that will be in effect until August 9, 2013 can elect to waive the Student Injury and Sickness Insurance Plan. Recognizing that health coverage may change, and as required by state law, at the beginning of each academic year students will be asked to provide proof of comparable coverage in order to waive the Student Injury and Sickness Insurance Plan.

### *Waiver/Enrollment Process*

To document proof of comparable coverage or to enroll in the Student Injury and Sickness Insurance Plan an online waiver/enrollment form must be completed and submitted by the deadline.

1. Go to www.gallagherkoster.com/AnnaMaria
2. Click on "Student Waive/Enroll"
3. Create a user account or log in (if a returning user)
4. Select the Red "I want to Waive" or the Green "I want to Enroll" button. If waiving the insurance, please have your current health insurance ID card ready as you will need this information in order to complete the waiver form.

Immediately upon submitting the Annual Waiver or Enrollment Form, you will receive a confirmation number indicating that the form has been successfully submitted. Print this confirmation number for your records. If you do not receive a confirmation number, you will need to correct any errors and resubmit the form. The online process is the only accepted process for waiving coverage.

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

International students can only waive the Student Injury and Sickness Insurance Plan if they are covered by an insurance plan of comparable based in the United States.

In the event students waive the Student Injury and Sickness Insurance Plan and then lose current 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. For petitions received after the 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Koster. If approved, the premium will not be prorated.

### Waiver/Enrollment Deadline

The deadline for students to complete the Online Waiver or Enrollment Form for annual coverage is September 28, 2012 and January 31, 2013 for students newly enrolled for the Spring Semester. Students who waive the Student Injury and Sickness Insurance Plan in the fall waive coverage for the entire policy year. The Online Waiver/Enrollment process is the only accepted process for making your insurance selection. Students who do not submit the Online Waiver Form by the deadline will be enrolled in and billed for the Student Injury and Sickness Insurance Plan.

## Schedule of Medical Expense Benefits

**Injury and Sickness**

**Maximum Benefit: $100,000 Paid As Specified Below (Per Insured Person) (Per Policy Year)**

**Deductible Preferred Provider: $50 (Per Insured Person) (Per Policy Year)**

**Deductible Out-of-Network: $200 (Per Insured Person) (Per Policy Year)**

**Coinsurance Preferred Provider: 90% except as noted below**
**Coinsurance Out-of-Network: 70% except as noted below**

**Out-of-Pocket Maximum Preferred Provider: $5,000 (Per Insured Person, Per Policy Year)**

**Out-of-Pocket Maximum Out-of-Network: $10,000 (Per Insured Person, Per Policy Year)**

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $100,000.

Then Preferred Providers of this plan is HPHC Insurance Company Network.

If care is received from a Preferred Provider, any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expenses is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% up to the policy Maximum Benefit subject to any benefit maximums that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. The Copays and per service Deductibles and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays and per service Deductibles.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Covered Medical Expenses include:

PA = Preferred Allowance U&C = Usual & Customary Charges

| INPATIENT | Preferred Provider HPHC Insurance Company Network | Out of Network Provider |
|---|---|---|
| **Room and Board Expense,** daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital. | 90% of PA | 70% of U&C |
| **Intensive Care** | 90% of PA | 70% of U&C |

| INPATIENT | Preferred Provider HPHC Insurance Company Network | Out of Network Provider |
|---|---|---|
| **Hospital Miscellaneous Expenses,** such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. | 90% of PA | 70% of U&C |
| **Routine Newborn Care** | Paid as any other Sickness/ See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care | |
| **Physiotherapy** | 90% of PA | 70% of U&C |
| **Surgeon's Fees,** if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. The first procedure will be paid in accordance with our standard reimbursement policy. | 90% of PA | 70% of U&C |
| **Assistant Surgeon** | 90% of PA | 70% of U&C |
| **Anesthetist,** professional services administered in connection with Inpatient surgery. | 90% of PA | 70% of U&C |
| **Registered Nurse's Services,** private duty nursing care. | 90% of PA | 70% of U&C |
| **Physician's Visits,** non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery. | 90% of PA | 70% of U&C |
| **Pre-Admission Testing,** payable within 3 working days prior to admission. | 90% of PA | 70% of U&C |
| **OUTPATIENT** | | |
| **Surgeon's Fees,** if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. The first procedure will be paid in accordance with our standard reimbursement policy. | 90% of PA | 70% of U&C |

| OUTPATIENT | Preferred Provider HPHC Insurance Company Network | Out of Network Provider |
|---|---|---|
| **Day Surgery Miscellaneous,** related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index. | 90% of PA | 70% of U&C |
| **Assistant Surgeon** | 90% of PA | 70% of U&C |
| **Anesthetist,** professional services administered in connection with outpatient surgery. | 90% of PA | 70% of U&C |
| **Physician's Visits,** benefits for Physician's Visits do not apply when related to Physiotherapy. Benefits include surgery when performed in the Physician's office. | 100% of PA/ $25 Copay per visit | 80% of U&C |
| **Physiotherapy,** benefits are limited to one visit per day. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy.<br>Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.<br>*(See also Benefits for Treatment of Speech, Hearing and Language Disorders)* | 90% of PA | 70% of U&C |
| **Medical Emergency Expenses,** attending Physician's charges, x-rays, laboratory procedures, tests and procedures, injections, and facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.<br>*(Copay / per visit Deductible is in addition to Policy Deductible.)(The Copay /per visit Deductible will be waived if admitted to the Hospital.)* | 90% of PA/ $100 Copay per visit | 70% of U&C/ $100 Deductible per visit |
| **Diagnostic X-ray Services** | 90% of PA | 70% of U&C |
| **Radiation Therapy** | 90% of PA | 70% of U&C |
| **Chemotherapy** | 90% of PA | 70% of U&C |
| **Laboratory Services** | 90% of PA | 70% of U&C |
| **Tests & Procedures,** diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy. | 90% of PA | 70% of U&C |

| OUTPATIENT | Preferred Provider HPHC Insurance Company Network | Out of Network Provider |
|---|---|---|
| **Injections,** when administered in the Physician's office and charged on the Physician's statement. | 90% of PA | 70% of U&C |
| **Prescription Drugs and medicines lawfully obtainable only upon written prescription of a Physician.** *(Mail order prescription drugs through UHPS at 2.5 times the retail Copay up to a 90 day supply.)* | UnitedHealthcare Network Pharmacy (UHPS) $15 Copay per prescription for Tier 1 $30 Copay per prescription for Tier 2 $50 Copay per prescription for Tier 3 up to a 31-day supply per prescription | No Benefits |
| **OTHER** | | |
| **Ambulance Services** | 80% of PA | 80% of U&C |
| **Durable Medical Equipment,** a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. *($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum Per Policy Year are not included in the $100,000 Maximum Benefit.) (See also Benefits for Prosthetic Devices and Repair)* | 90% of PA | 70% of U&C |
| **Consultant Physician Fees,** when requested and approved by attending Physician. | 100% of PA/ $25 Copay per visit | 80% of U&C |
| **Dental Treatment,** made necessary by Injury to Sound, Natural Teeth only. *($500 maximum Per Policy Year) (Benefits are not subject to the $100,000 Maximum Benefit.)* | 90% of PA | 90% of U&C |
| **Mental Illness Treatment** | Paid as any other Sickness / See Benefits for Treatment of Mental Disorders | |
| **Substance Use Disorder Treatment** | Paid as any other Sickness / See Benefits for Treatment of Mental Disorders | |
| **Maternity** | Paid as any other Sickness / See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care | |

| OTHER | Preferred Provider HPHC Insurance Company Network | Out of Network Provider |
|---|---|---|
| **Complications of Pregnancy** | Paid as any other Sickness / See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care | |
| **Preventive Care Services,** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.<br>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.<br>*See also Benefits for Cytologic Screening and Mammographic Examinations, Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care, and Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services, and Benefits for Dependent Children Preventive Care.* | 100% of PA | No Benefits |
| **Reconstructive Breast Surgery Following Mastectomy,** in connection with a covered Mastectomy. | Paid as any other Sickness / See Benefits for Initial Prosthetic Device and Reconstructive Surgery Incident to Mastectomy | |
| **Diabetes Services,** in connection with the treatment of diabetes. *See Benefits for Treatment of Diabetes* | Paid as any other Sickness | |
| **Home Health Care** | See Benefits for Home Health Care | |
| **Hospice Care,** *(Benefits are not subject to the $100,000 Maximum Benefit)* | See Benefits for Hospice Care | |
| **Urgent Care Center,** facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits. | 90% of PA/ $50 Copay per visit | 70% of U&C/ $50 Deductible per visit |

## UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and Copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 1-877-417-7345 for the most up-to-date tier status.

$15 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply

$30 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply

$50 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply

Mail order Prescription Drugs are available at 2.5 times the retail copy up to a 90 day supply.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com and log in to your online account or call 1-877-417-7345.

### Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

### Definitions

**Prescription Drug or Prescription Drug Product** means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

**Prescription Drug List** means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service at 1-877-417-7345.

## Preferred Provider Network

The **HPHC Insurance Company Network** is a network of Physicians, Hospitals, and other health care providers who have contracted to provide specific medical care at negotiated prices.

**"Preferred Providers"** are the Physicians, Hospitals and other health care providers who participate in the HPHC Insurance Company Network.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-877-320-4347 and/or by asking the provider when making an appointment for services.

**"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 the Insureds responsibility.

**"Network Area"** means the geographic service area approved by the Massachusetts Division of Insurance.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

### Inpatient Expenses

**PREFERRED PROVIDERS** - Eligible Inpatient expenses at a Preferred Hospital will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits Preferred Hospitals include HPHC Insurance Company Network facilities. Call 1-877-320-4347 for information about Preferred Hospitals.

**OUT OF NETWORK PROVIDERS** - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

### Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

### Professional & Other Expenses

Benefits for Covered Medical Expenses provided by HPHC Insurance Company Network will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

## Maternity Testing

This policy may not cover all routine, preventive, or screening examinations or testing. The policy will cover those Maternity Tests as required by the Health Resources and Services Administration's comprehensive guidelines for women's preventive care and screenings, as updated, with no cost share when received from a Preferred Provider, as referenced in the Preventive Care Services Benefits listed in the Schedule.

In addition, the following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met.

Initial screening at first visit:

- Pregnancy test: urine human chorionic gonatropin (HCG)
- Blood type
- Pregnancy-associated plasma protein-A (PAPPA) (first trimester only)
- Free beta human chorionic gonadotrophin (hCG) (first trimester only)
- Coombs test

Each visit: Urine analysis

Once during first trimester: Ultrasound

Once during second trimester

- Ultrasound (anatomy scan)
- Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a

Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS)

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-866-948-8472.

## Accidental Death and Dismemberment

### Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

**For Loss Of:**

| | |
|---|---|
| Life | $ 5,000 |
| Two or More Members | $ 5,000 |
| One Member | $ 2,500 |
| Thumb or Index Finger | $ 1,250 |

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

## Coordination of Benefits

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

Definitions

(1) **Allowable Expenses:** Any necessary, reasonable, and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person.

An Allowable Expense to a Secondary Plan includes the value or amount of any Deductible Amount or Coinsurance Percentage or amount of otherwise Allowable Expenses which was not paid by the Primary or first paying Plan.

(2) **Plan:** A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services. Such group coverages include: (a) group or blanket insurance coverage, or any other group type contract or provision thereof; this will not include school accident coverage, Qualifying Student Health Insurance Programs (QSHIPs), or other student health plans designated as excess only or always secondary; (b) service plan contracts, group practice and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) to the extent permitted by law, coverage under governmental programs, including Medicare, and any coverage required or provided by statute.

(3) **Primary:** The Plan which pays regular benefits.

(4) **Secondary:** The Plan which is not a Primary Plan.

(5) **We, Us or Our:** The Company named in the policy to which this endorsement is attached.

**Effect on Benefits** - If an Insured Person has medical and/or drug coverage under any other Plan, all of the benefits provided are subject to coordination of benefits.

During any policy year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Plan may not be more than the Allowable Expenses.

During any policy year or benefit period, We may reduce the amount We will pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made.

However, if: (1) the other Plan contains a section which provides for determining its benefits after Our benefits have been determined; and (2) the order of benefit determination stated herein would require Us to determine benefits before the other Plan, then the benefits of such other Plan will be ignored in determining the benefits We will pay.

This Plan determines its order of benefits using the first of the following rules which applies:

(1) If the Insured's other Plan does not have Coordination of Benefits, that Plan pays first.

(2) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.

(3) Dependent Child/Parents Not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

a. the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year; but

b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

c. However, if the other Plan does not have the rule described in a. above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the birthday rule will determine the order of benefits.

(4) **Dependent Child/Separated or Divorced Parents**. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. first, the Plan of the parent with custody of the child;
2. then, the Plan of the spouse of the parent with the custody of the child; and
3. finally, the Plan of the parent not having custody of the child.

If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

(5) **Longer/Shorter Length of Coverage**. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

**Right to Recovery and Release of Necessary Information** - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

**Facility of Payment and Recovery** - Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

### *Benefits for Cardiac Rehabilitation*

Benefits will be paid the same as any other Sickness for Cardiac Rehabilitation. Cardiac Rehabilitation shall mean multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a Hospital or other setting and which shall meet standards promulgated by the commissioner of public health. Benefits shall include, but not be limited to, outpatient treatment which is to be initiated within twenty-six (26) weeks after diagnosis of such disease.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Infertility Treatment*

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Infertility for Insured Persons residing within the Commonwealth of Massachusetts to the same extent that benefits are provided for other pregnancy-related procedures. Benefits will include, but not be limited to, the following Non-experimental Infertility Procedures:

1) Artificial Insemination (AI);
2) In Vitro Fertilization and Embryo Placement (IVF-EP);
3) Gamete Intra-Fallopian Transfer (GIFT);
4) Sperm, egg and/or inseminated egg procurement, processing and banking, to the extent such costs are not covered by the donor's insurer, if any;
5) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility; and
6) Zygote Intrafallopian Transfer (ZIFT).

Benefits are not provided for the following Experimental Infertility Procedures:

1) Any Experimental Infertility Procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner;
2) Surrogacy;
3) Reversal of Voluntary Sterilization; and
4) Cryopreservation of eggs.

**"Infertility"** means:

- For females 35 and younger shall mean the inability to conceive or produce conception during a period of one year.
- For females over the age of 35 shall mean the inability to conceive or produce conception during a period of six months.

For the purposes of meeting the criteria for infertility, if a person conceived but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included on the calculation of the 1 year or 6 month period as applicable.

**"Non-experimental Infertility Procedures"** means a procedure which is: 1) recognized as such by the American Fertility Society (AFS) or the American College of Obstetrics and Gynecology (ACOG) or another infertility expert recognized as such by the Commission; and 2) incorporated as such in this provision by the Commissioner after a public hearing pursuant to M.G.L. c. 30A.

**"Experimental Infertility Procedures"** means a procedure not yet recognized as non-experimental.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy, except that any Pre-Existing Condition exclusion or waiting period shall not apply to benefits for Infertility treatment.

### *Benefits for Enteral Formula*

Benefits will be paid the same as any other Sickness for nonprescription enteral formulas for home use when a Physician has issued a written order for such formula and when Medically Necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Benefits for inherited diseases of amino acids and organic acids shall include food products modified to be low protein limited to $5,000 annually for any Insured Person. Benefits are provided for formulas that are taken orally as well as those that are administered by tube.

Benefits shall be subject to a copayment for a 30-day supply of enteral formula that is equal to the copayment required for outpatient Physician Visits.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Bone Marrow Transplants for Treatment of Breast Cancer*

Benefits will be paid the same as any other Sickness for a bone marrow transplant or transplants for Insureds who have been diagnosed with breast cancer that has progressed to metastatic disease. Insureds must meet the criteria established by the Department of Public Health and which are consistent with medical research protocols reviewed and approved by the National Cancer Institute.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Human Leukocyte Antigen or Histocompatibility Locus Antigen Testing*

Benefits will be paid the same as any other Sickness for human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability for potential donors for Insured Persons. Benefits shall include the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Initial Prosthetic Device and Reconstructive Surgery Incident to Mastectomy*

Benefits will be paid the same as any other Sickness for a Mastectomy and the initial prosthetic device or reconstructive surgery incident to the Mastectomy. Benefits shall be provided for reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy. When a Mastectomy is performed and there is no evidence of malignancy, benefits will be limited to the cost of the prosthesis or reconstructive surgery to within 2 years after the date of the Mastectomy.

"Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care*

Benefits will be paid the same as any other Sickness for the expense of prenatal care, childbirth and post partum care. Benefits will be provided for a minimum of forty-eight hours of in-patient care following a vaginal delivery and a minimum of ninety-six hours of in-patient care following a caesarean section for a mother and her newly born child including routine well-baby care. Any decision to shorten such minimum stay shall be made by the attending Physician in consultation with the mother. Any such decision shall be made in accordance with rules and regulations promulgated by the Department of Public Health. Said regulations shall be relative to early discharge, defined as less than forty-eight hours for a vaginal delivery and ninety-six hours for a caesarean delivery. Post-delivery care shall include, but not be limited to, home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit shall be conducted by a Physician. Additional Medically Necessary home visits shall be provided upon recommendation by a Physician.

Benefits will be paid the same as any other Sickness for Medically Necessary special medical formulas which are approved by the commissioner of the Department of Public Health, when prescribed by a Physician to protect the unborn fetuses of pregnant women with phenylketonuria.

Maternity, Childbirth, Well-Baby and Post Partum Care services covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

All other Maternity, Childbirth, Well-Baby and Post Partum Care benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Scalp Hair Prostheses*

Benefits will be paid for expenses for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia when a written statement by a Physician is furnished stating that the scalp hair prosthesis is Medically Necessary. Benefits are limited to $350 per Policy Year.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Cytologic Screening and Mammographic Examinations*

Benefits will be paid the same as any other Sickness for: 1) an annual cytologic screening for women eighteen (18) years of age or older; and 2) a baseline mammogram for women between the ages thirty-five (35) and forty (40) and for an annual mammogram for women forty (40) years of age and older.

Cytologic Screening and Mammographic Examinations covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

All other Cytologic Screening and Mammographic Examinations benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Treatment of Speech, Hearing and Language Disorders*

Benefits will be paid the same as any other Injury or Sickness for Insured Persons for Medically Necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists. Benefits will be paid for services provided in a Hospital, clinic or private office. Benefits will not be provided for the diagnosis or treatment of speech, hearing and language disorders for services provided in a school-based setting.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Hospice Care*

When an Insured Person is diagnosed with a covered Injury or Sickness, and therapeutic intervention directed toward the cure of the Injury or Sickness is no longer appropriate, and the Insured's medical prognosis is one in which there is a life expectancy of six months or less as a direct result of such Injury or Sickness, benefits will be payable for the Usual and Customary Charges for services and supplies for hospice care prescribed by a Physician and provided by a licensed hospice agency, organization or unit. This benefit does not cover non-terminally ill patients who may be confined in: a convalescent home, rest or nursing facility; a skilled nursing facility; a rehabilitation unit or a facility that provides treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts, or alcoholics. For this benefit to be payable, a written statement from the attending Physician that the Insured is terminally ill within the terms of this benefit and a written statement from the hospice certifying the days on which services were provided must be furnished to the Company.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Home Health Care Services*

Benefits will be paid the same as any other Sickness for Home Health Care Services. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aid and the use of durable medical equipment and supplies shall be provided to the extent such services are determined to be a Medically Necessary component of said nursing and physical therapy. Benefits for Home Health Care Services are payable only when such services are Medically Necessary and provided in conjunction with a Physician approved Home Health Care Services plan. Durable medical equipment and supplies provided as part of an approved Home Health Care Services plan will not be subject to any policy limitations regarding durable medical equipment and supplies.

"Home health care services" means health care services for an Insured Person by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a patient's residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services. Said services shall include, but not be limited to, nursing and physical therapy.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Hypodermic Syringes or Needles*

Benefits will be paid for the Covered Medical Expenses incurred for Medically Necessary hypodermic syringes and needles.

Benefits shall be subject all Deductible, Copayments, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Dependent Children Early Intervention Services*

Benefits will be paid the same as any other Sickness for early intervention services for Dependent children from birth to their third birthday. Certified early intervention specialists in accordance with an early intervention program approved by the Department of Public Health and in accordance with applicable certification requirements shall provide early intervention services.

Benefits shall not be subject to any Deductible, Copayment, Coinsurance provisions of the policy. Benefits shall be subject to all limitations and any other provisions of the policy.

### *Benefits for Treatment of Diabetes*

Benefits will be paid the same as any other Sickness for Insured Persons for Medically Necessary services and supplies for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes when prescribed by a Physician.

Benefits will be paid for the following, subject to any applicable Deductibles, Copayments and Coinsurance as set forth on the Schedule of Benefits:

1. **Prescription Drugs:** blood glucose monitoring strips for home use; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; insulin pumps and insulin pump supplies; insulin pens and prescribed oral diabetes medications that influence blood sugar levels;
2. **Durable medical equipment:** blood glucose monitors; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind;
3. **Laboratory/radiological services:** including glycosylated hemoglobin, or HbAlc tests; urinary protein/microalbumin and lipid profiles;
4. **Prosthetics:** therapeutic/molded shoes and shoe inserts prescribed by a Physician and approved by the Federal Drug Administration for the purposes for which they were prescribed for Insureds who have severe diabetic foot disease; and
5. **Outpatient services:** diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a Physician certified in diabetes health care.

As used in this section, a "Physician certified in diabetes health care" means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Off-Label Drug Use for Cancer or HIV/AIDS*

If benefits are payable for Prescription Drugs under this policy (see Schedule of Benefits), then benefits will be paid the same as any other Prescription Drug for any drug prescribed to treat an Insured Person for cancer or HIV/AIDS if the drug is recognized treatment for that indication in one of the Standard Reference Compendia, in Medical Literature, or in the Association of Community Cancer Centers' Compendia-Based Drug Bulletin.

"Standard Reference Compendia" means (a) the United States Pharmacopeia Drug Information; (b) the American Medical Association Drug Evaluations; or (c) the American Hospital Formulary Service Drug Information.

"Medical Literature" means scientific studies published in any peer-reviewed national professional journal.

For such Prescription Drugs that are payable due to establishment by the commissioner as payable after a review of the panel of medical experts as outlined in Massachusetts Insurance Code, 175:47L, benefits will be paid for such drugs that are not included in any of the standard reference compendia or in the medical literature for the treatment of cancer.

Benefits shall include Medically Necessary services associated with the administration of such drugs.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Treatment of Mental Disorders*

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, referred to in this benefit as the "DSM":

(1) schizophrenia,
(2) schizoaffective disorder,
(3) major depressive disorder,
(4) bipolar disorder,
(5) paranoia and other psychotic disorders,
(6) obsessive-compulsive disorder,
(7) panic disorder,
(8) delirium and dementia,
(9) affective disorders,
(10) eating disorders,
(11) post traumatic stress disorder, and
(12) substance abuse disorders.

Benefits will be paid the same as any other Sickness for the diagnosis and Medically Necessary active treatment of any mental disorder as described in the most recent edition of the DSM that is approved by the Commissioner of Mental Health.

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, as defined by sections 22 and 24 of chapter 265, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant to subparagraph (C) of paragraph (2) of subsection (b) of section 3 of chapter 258C.

Benefits will be paid the same as any other Sickness for an Insured Person under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by a Physician, or is evidenced by conduct, including, but not limited to:

1) an inability to attend school as a result of such disorder,
2) the need to hospitalize such an Insured Person as a result of such disorder, or
3) a pattern of conduct or behavior caused by such disorder which poses a serious danger to self or others.

Such benefits to an Insured Person who is engaged in an ongoing course of treatment shall continue beyond an Insured Person's nineteenth birthday until said course of treatment, as specified in such an Insured Person's treatment plan, is completed and while the policy under which such benefits first became available remains in effect, or subject to a subsequent policy which is in effect.

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of all other mental disorders not otherwise provided for in this benefit section and which are described in the most recent edition of DSM.

Benefits shall include inpatient, intermediate, and outpatient services that are Medically Necessary and provided in the least restrictive clinically appropriate setting.

Inpatient services may be provided in a general Hospital licensed to provide such services, in a facility under the direction and supervision of the Department of Mental Health, in a private mental Hospital licensed by the Department of Mental Health, or in a substance abuse facility licensed by the Department of Public Health.

Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Department of Public Health or the Department of Mental Health.

Outpatient services may be provided in a licensed Hospital, a mental health or substance abuse clinic licensed by the Department of Public Health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Benefits will be paid the same as any other Sickness for psychopharmacological services and neuropsychological assessment services.

When necessary for administration of claims under this benefit section, consent to the disclosure of information regarding services for mental disorders will be required on the same basis as disclosure of information for other Sickness or Injury.

Benefits will not be payable for mental health benefits or services: which are provided to a person who is incarcerated, confined or committed to a jail, house of correction or prison, or custodial facility in the department of youth services within the commonwealth or one of its political subdivisions; which constitute educational services required to be provided by a school committee pursuant to section 5 of chapter 71B; or which constitute services provided by the Department of Mental Health.

"Licensed mental health professional" means a Physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services*

Benefits will be paid the same as any other Sickness for outpatient hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services. Outpatient contraceptive services include consultations, examinations, procedures and medical services for all United States Food and Drug Administration (FDA) approved contraceptive methods to prevent pregnancy.

If the policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Sickness for FDA approved hormone replacement therapy and outpatient prescription contraceptive drugs or devices.

Hormone Replacement Therapy and Outpatient Contraceptive Services covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

All other Hormone Replacement Therapy and Outpatient Contraceptive Services benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Prosthetic Devices and Repairs*

Benefits will be paid for Medically Necessary Prosthetic Devices and repairs under the same terms and conditions that apply to other durable medical equipment except that no annual or lifetime dollar maximum applicable to other durable medical equipment shall be imposed unless the annual or lifetime dollar maximum applies in the aggregate to all items and services covered under the policy.

"Prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or leg.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Qualified Clinical Trials for Treatment of Cancer*

Benefits will be paid the same as any other Sickness for Patient Care Service furnished pursuant to a Qualified Clinical Trial.

Patient Care Service means a health care item or service that is furnished to an individual enrolled in a Qualified Clinical Trial which is consistent with the Usual and Customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the clinical trial.

Qualified clinical trial means a clinical trial that meets the following conditions:

1. the clinical trial is to treat cancer;
2. the clinical trial has been peer reviewed and approved by one of the following;
   a. United States National Institutes of Health;
   b. A cooperative group or center of the National Institutes of Health;
   c. A qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
   d. The United States Food and Drug Administration pursuant to an investigational new drug exemption;
   e. The United States Departments of Defense or Veterans Affairs; or
   f. With respect to Phase II, III and IV clinical trials only, a qualified institutional review board.
3. the facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience;
4. with respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center;
5. the patient meets the patient selection criteria defined in the study protocol for participation in the clinical trial;
6. the patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards;
7. the available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial;
8. the clinical trial does not unjustifiably duplicate existing studies; and
9. the clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Newborn or Adopted Children*

Benefits will be paid for Newborn Infants, including Newborn Infants of a Dependent, from the moment of birth the same as any other Insured Dependent. Benefits shall also be provided for Adopted or Adoptive Children of the Insured Person immediately from the date of the filing of a petition to adopt under chapter two hundred and ten and thereafter if the child has been residing in the home of the Insured Person as a foster child for whom the Insured Person has been receiving foster care payments, or, in all other cases, immediately from the date of placement by a licensed placement agency of the child for purposes of adoption in the home of the Insured Person. Benefits for Newborn Infants and Adoptive Children shall include treatment of Injury and Sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth.

Benefits shall include those special medical formulas which are approved by the commissioner of the Department of Public Health, prescribed by a Physician, and are Medically Necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or Medically Necessary to protect the unborn fetus of a pregnant woman with phenylketonuria.

Benefits shall include screening for lead poisoning on the basis required by the Department of Public Health.

Benefit shall include a newborn hearing screening test to be performed before the Newborn Infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by regulations of the Department of Public Health.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Dependent Children Preventive Care*

Benefits will be paid for the Usual and Customary Charges for those preventive and primary services delivered or supervised by a Physician that are rendered to a Dependent child of an Insured from the date of birth through the attainment of six years of age. Benefits include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the next year, annually until age six. Benefits shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Physician.

Dependent Children Preventive Care services covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

All other Dependent Children Preventive Care benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

### *Benefits for Christian Science Services*

Benefits will be paid for services delivered in accordance with the healing practices of Christian Science. The cost sharing and any aggregate maximum per day applicable to Room and Board and Hospital Miscellaneous Expenses or, if combined, Hospital Expense, stated in the Schedule of Benefits will apply to services in a Christian Science sanatorium.

All Deductibles, Copayments, Coinsurance, limitations or any other provisions of the policy shall also apply to the services of Christian Science sanatoria. Religious aspects of care are not covered under this benefit.

### *Benefits for Treatment of Autism Spectrum Disorders*

Benefits will be paid the same as any Sickness for the Diagnosis and Treatment of Autism Spectrum Disorders.

"Autism Spectrum Disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

"Diagnosis of Autism Spectrum Disorders" means Medically Necessary assessments, evaluations including neuropsychological evaluations, genetic testing, or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders.

"Treatment of Autism Spectrum Disorders" includes the following types of care which are prescribed, provided, or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed Physician or licensed psychologist who determines that care to be Medically Necessary:

1. habilitative or rehabilitative care, including professional, counseling and guidance services and treatment programs, including but limited to, Applied Behavior Analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functions of an individual;
2. pharmacy care, including medications prescribed by a licensed Physician and health-related services deemed Medically Necessary to determine the need or effectiveness of the medications;
3. psychiatric care, which includes direct or consultative services provided by a licensed psychiatrist;
4. psychological care, which includes direct or consultative services provided by a licensed psychologist; and
5. therapeutic care, including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers.

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

Benefits shall not be subject to a limit on the number of visits an Insured Person may make to an autism services provider.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

## Definitions

**ADOPTED OR ADOPTIVE CHILD** means:

1) a child from the date of the filing of a petition to adopt who has been residing in the home of the Insured as a foster child and the Insured has been receiving foster care payments, provided the person adopting the child is insured under the policy on the date the petition is filed; or
2) a child from the date of placement by a licensed placement agency for purposes of adoption in the home of the Insured provided the person adopting the child is insured under this policy on the date the child is placed with the Insured.

Such child will be covered under the policy for the first 31 days after:

1) date of the filing of a petition to adopt a foster child; or
2) date of placement of a child for purposes of adoption.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, a) apply to the Company, and b) pay the required additional premium (if any) for the continued coverage within 31 days after:

1) filing of a petition to adopt; or
2) date of placement for purposes of adoption.

If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the date of:

1) filing of a petition to adopt; or
2) date of placement of a child for purposes of adoption.

**COINSURANCE** means the percentage of Covered Medical Expenses that the Company pays.

**COMPLICATION OF PREGNANCY** means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

**COPAY/COPAYMENT** means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

**COVERED MEDICAL EXPENSES** means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

**CUSTODIAL CARE** means services that are any of the following:

1) Non-health related services, such as assistance in activities.
2) Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3) Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**DEDUCTIBLE** means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

**DEPENDENT** means the spouse (husband or wife) or Domestic Partner of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

Dependent shall also include any Newborn Infant of a dependent of the Named Insured.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap.
2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

**ELECTIVE SURGERY OR ELECTIVE TREATMENT** means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

**EXPERIMENTAL OR INVESTIGATIVE TREATMENT** means a service, supply, procedure, device or medication that meets any of the following:

1. a drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or
2. a treatment, or the "informed consent" form used with a treatment, that was reviewed and approved by the treating facility's institutional review board or other body servicing a similar function, or federal law requires such review or approval; or
3. reliable evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. reliable evidence shows that prevailing opinion among experts regarding the treatment is that more studies or clinical trials are necessary to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence, as used in this definition, means only published reports and articles in the authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment; or the written informed consent form used by the treating facility or by another facility studying substantially the same treatment.

**HOSPITAL** means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

**HOSPITAL CONFINED/HOSPITAL CONFINEMENT** means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

**INJURY** means bodily injury which is all of the following:

1) directly and independently caused by specific accidental contact with another body or object.
2) unrelated to any pathological, functional, or structural disorder.
3) a source of loss.
4) treated by a Physician within 30 days after the date of accident.
5) sustained while the Insured Person is covered under this policy.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

**INPATIENT** means an uninterrupted confinement that follows formal admission to a Hospital by reason of an Injury or Sickness for which benefits are payable under this policy.

**INSURED PERSON** means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term "Insured" also means Insured Person.

**INTENSIVE CARE** means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care.
2) Sub-acute intensive care.
3) Intermediate care units.
4) Private monitored rooms.
5) Observation units.
6) Other facilities which do not meet the standards for intensive care.

**MEDICAL EMERGENCY** means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in:

1) placing the health of the Insured Person in serious jeopardy;
2) serious impairment to body function, or serious dysfunction of any body organ or part; or
3) with respect to a pregnant woman, the health of the woman or her unborn child.

**MEDICAL NECESSITY or MEDICALLY NECESSARY** means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury.
2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury.
3) In accordance with the standards of good medical practice.
4) Not primarily for the convenience of the Insured, or the Insured's Physician.
5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means both:

1) The Insured requires acute care as a bed patient.
2) The Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement.

**MENTAL ILLNESS** means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

**NAMED INSURED** means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

**NEWBORN INFANT** means any child born of an Insured or of the Insured's Dependent while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

**OUT-OF-POCKET MAXIMUM** means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medial Expenses will be paid at 100% for the remainder of the Policy Year according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

1) Deductibles.
2) Copays.
3) Expenses that are not Covered Medical Expenses.

**PHYSICIAN** means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family. This includes but is not limited to certified registered nurse anesthetists, nurse practitioners, certified nurse midwives, podiatrists, chiropractors, optometrists or any other legally licensed practitioner of the healing arts who is practicing within the scope of his/her license. Physicians eligible for reimbursement under the terms of this policy shall include pediatric specialty care Physicians, including mental health care, by Physicians with recognized expertise in specialty pediatrics to eligible Insureds requiring such services.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

**PHYSIOTHERAPY** means any form of the following short-term rehabilitation therapies: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

**POLICY YEAR** means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

**PRE-EXISTING CONDITION** means any condition (1) which manifested itself during the 6 months immediately preceding the Insured's Effective Date of coverage under this policy and would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received; or (2) a pregnancy existing on the Insured's Effective Date of coverage under this policy.

**PRESCRIPTION DRUGS** mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

**REGISTERED NURSE** means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

**SICKNESS** means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

**SOUND, NATURAL TEETH** means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

**SUBSTANCE USE DISORDER** means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

**URGENT CARE CENTER** means a facility that provides treatment required to prevent serious deterioration of the Insured Person's health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

**USUAL AND CUSTOMARY CHARGES** means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

## Exclusions and Limitations

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

1. Acne;
2. Acupuncture;
3. Allergy, including allergy testing;
4. Addiction, such as: nicotine addiction, except as specifically provided in the policy; and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
5. Biofeedback;
6. Circumcision;
7. Congenital conditions, except as specifically provided for Newborn or Adopted Infants;
8. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
9. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;

10. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
11. Elective Surgery or Elective Treatment;
12. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
13. Health spa or similar facilities; strengthening programs;
14. Hearing examinations; hearing aids except as specifically provided in the policy; or other treatment for hearing defects and problems, except as specifically provided in the policy; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
15. Hirsutism; alopecia;
16. Hypnosis;
17. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
18. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
19. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
20. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
21. Investigational services;
22. Lipectomy;
23. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
24. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months; or under a previous qualifying health plan, provided such coverage was in force within 63 days prior to the Insured's Effective Date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;
25. Prescription Drugs, services or supplies as follows:
    a. Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
    b. Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    d. Products used for cosmetic purposes;
    e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f. Anorectics - drugs used for the purpose of weight control;
    g. Sexual enhancement drugs, such as Viagra;
    h. Growth hormones; or
    i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

26. Family planning; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery;
27. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;
28. Routine Newborn Infant Care, well-baby nursery and related Physician charges, except as specifically provided in the policy Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care;
29. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the Preventive Care Services benefit or except as specifically provided in the policy;
30. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
31. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
32. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
33. Supplies, except as specifically provided in the policy;
34. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
35. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
36. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
37. Weight management, weight reduction, nutrition programs, treatment for obesity, (except surgery for morbid obesity), surgery for removal of excess skin or fat, except as specifically provided in the policy.

## Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

## Medical Emergency Treatment

In the event of Injury or Sickness, the Insured should contact their Physician or report to the Student Health Service if such services are available to the Insured. Should the Insured have a condition that a prudent layperson would consider a Medical Emergency, the Insured should go to the nearest Physician or Hospital or call the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent. An Insured is not required to contact the Company prior to treatment. An Insured will not be denied coverage for medical and transportation expenses incurred as a result of a Medical Emergency involving a mental health condition.

After 72 hours of Inpatient care and if an Insured has been stabilized, the Company has the right to require an Insured to be transferred to a Preferred Provider Hospital in order to continue benefit levels at the Preferred Provider rate. Any such transfer must be approved by the attending Physician. If the Insured is not considered stabilized at that time, the Company has the right to require transfer to a Preferred Provider Hospital when the Insured is deemed stabilized by the attending Physician. If the Insured does not accept transfer, benefits will be payable at the Out-of-Network rate following the day in which such transfer was possible.

## Scholastic Emergency Services: Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you and your insured spouse or Domestic Partner and minor child(ren) are eligible for Scholastic Emergency Services (SES). The requirements to receive these services are as follows:

International Students, insured spouse or Domestic Partner and insured minor child(ren): You are eligible to receive SES worldwide, except in your home country.

Domestic Students, insured spouse or Domestic Partner and insured minor child(ren): You are eligible for SES when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

SES includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, Inc.; any services not arranged by SES, Inc. will not be considered for payment.

Key Services include:

* Medical Consultation, Evaluation and Referrals
* Foreign Hospital Admission Guarantee
* Emergency Medical Evacuation
* Medically Supervised Repatriation
* Emergency Counseling Services
* Lost Luggage or Document Assistance
* Care for Minor Children Left Unattended Due to a Medical Incident
* Prescription Assistance
* Critical Care Monitoring
* Return of Mortal Remains
* Transportation to Join Patient
* Interpreter and Legal Referrals

Please visit www.gallagherkoster.com/AnnaMaria or your school's insurance coverage page at www.uhcsr.com for the SES Global Emergency Assistance Services brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States
(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

When calling the SES Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number; (located on health insurance card)
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached.

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at www.uhcsr.com for additional information, including limitations and exclusions pertaining to the SES program.

## Managed Care Information Provisions

### Provider Directories

Provider Directories for the HPHC Insurance Company Network may be obtained:

a) by calling 1-877-320-4347; or

b) by logging on to the website at www.gallagherkoster.com/AnnaMaria for information.

### Service Area Description

All counties in Massachusetts are included in the HPHC Insurance Company Network.

### Continuity of Coverage

1. If an Insured female is in her second or third trimester of pregnancy and her Physician providing care for her pregnancy is involuntarily disenrolled (other than disenrollment for quality-related reasons or for fraud), the Insured female may continue treatment with such Physician, consistent with the terms of this Certificate, for the period up to and including the Insured's first postpartum visit.
2. If an Insured is terminally ill and their Physician providing care in connection with said illness is involuntarily disenrolled (other than disenrollment for quality related reasons or for fraud) the Insured may continue treatment with such Physician consistent with the terms of this Certificate, until the Insured's death.
3. If a newly enrolled Insured is in an ongoing course of treatment and the Insured's Physician is not a participating provider in the Preferred Provider Network, benefits will be provided for such course of treatment for up to 30 days from the Effective Date of coverage, subject to the Pre-Existing Condition Limitation, consistent with the terms of this Certificate.

Such continuity of coverage will only apply if such Physician agrees to the following: (a) to accept reimbursement from the Company at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Insured in an amount that would exceed the cost sharing that could have been imposed if the Physician had not been disenrolled; (b) to adhere to the quality assurance standards of the Company or Network and to provide the Company with necessary medical information related to the care provided; and (c) to adhere to the Company's policies and procedures. This section does not require coverage of benefits that would not have been covered if the Physician involved had remained a Preferred Provider.

## Resolution of Grievances

### Internal Inquiry Process

The Insured will be notified in writing by the Company if a claim or any part of a claim is denied. The notice will include the specific reason or reasons for the denial and the reference to the pertinent plan provision(s) on which the denial was based.

If the Insured has a complaint about a claim denial, the Insured may call our Member Services telephone number 1-866-948-8472 for further explanation to informally resolve the complaint or contact the consumer assistance toll-free number maintained by the Office of Patient Protection at 1-800-436-7757. If the Insured is not satisfied with our explanation of why the claim was denied, the Insured, the Insured's authorized representative, or the Insured's provider may request an internal review of the claim denial.

The following is the Company's internal inquiry process:

1) The Insured must request in writing a benefit review within 60 days after receipt of the claim notice. This will be an informal reconsideration review process of the claim by a Claims Supervisor. This process is not used for clinical reviews. The Insured may not attend this review.
2) A decision will be made by the Claims Supervisor, within 3 business days after the receipt of the request for review or the date all information required from the Insured is received.
3) The Company will provide written notice to an Insured whose inquiry has not been explained or resolved to the Insured's satisfaction within three business days of the inquiry of the right to have the inquiry processed as an internal grievance under 105 CMR 128.300 through 128.313 at his/her option, including reduction of an oral inquiry to writing by the Company, written acknowledgment and written resolution of the grievance as set forth in 105 CMR 128.300 through 128.313. The Insured is not required to attend the grievance review.
4) The Company has a system for maintaining records for a period of two years of each inquiry communicated by an Insured or on his behalf and response thereto. These records shall be subject to inspection by the Commissioner of Insurance and the Office of Patient Protection.

### Internal Grievance Review

1) The internal grievance material must be submitted in writing, by electronic means at SGrievances@uhcsr.com or by calling our Member Services telephone number 1-866-948-8472 by the Insured or the authorized representative for consideration by the grievance reviewer. An oral grievance made by the Insured or the authorized representative shall be reduced to writing by the Company and a copy forwarded to the Insured within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company.
2) Within 15 business days after the Company receives the Insured's request for an internal grievance review, the Company must provide the Insured with a written acknowledgment of the receipt of the grievance, except where an oral grievance has been reduced to writing by the Company or this time period is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company.

3) Any grievance that requires the review of medical records, shall include the signature of the Insured, or the Insured's authorized representative on a form provided promptly by the Company authorizing the release of medical and treatment information relevant to the grievance, in a manner consistent with state and federal law. The Insured and the authorized representative shall have access to any medical information and records relevant to the grievance relating to the Insured which is in the possession of and under the control of the Company. The Company shall request said authorization from the Insured when necessary for requests reduced to writing by the Company and for any written requests lacking said authorization.

4) The Insured may or may not attend this review but is not required to do so.

5) An internal grievance review written decision will be issued to the Insured and, if applicable, the Insured's provider, within 30 business days of the receipt of the grievance. When a grievance requires the review of medical records, the 30 business day period will not begin to run until the Insured or the Insured's authorized representative submits a signed authorization for release of medical records and treatment information as required in 105 CMR 128.302(B). In the event that the signed authorization is not provided by the Insured or the Insured's authorized representative, if any, within 30 business days of the receipt of the grievance, the Company may, in its discretion, issue a resolution of the grievance without review of some or all of the medical records. The 30 business day time period for written resolution of a grievance that does not require the review of medical records, begins on the day immediately following the three business day time period for processing inquiries pursuant to 105 CMR 128.200, if the inquiry has not been addressed within that period of time; or on the day the Insured or the Insured's authorized representative, if any, notifies the Company that s/he is not satisfied with the response to any inquiry under 105 CMR 128.200 if earlier than the three business day time period. The time limits in 105 CMR 128.305 may be waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be an actively practicing Physician in the same or similar specialty who typically treat the medical condition, perform or provide the treatment that is the subject of the grievance to evaluate the matter. The written decision issued in a grievance review shall contain:

   A) The professional qualifications and licensure of the person or persons reviewing the grievance.

   B) A statement of the reviewer's understanding of the grievance.

   C) The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Company's position. In the case of a grievance that involves an adverse determination, the written resolution shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and shall at a minimum:

      1) identify the specific information upon which the adverse determination was based;

      2) discuss the Insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

      3) specify alternative treatment options covered by the Company, if any;

4) reference and include applicable clinical practice guidelines and review criteria; and

5) notify the Insured or the Insured's authorized representative of the procedures for requesting external review.

D) A reference to the evidence or documentation used as the basis for the decision.

E) A statement advising the Insured of his or her right to request a reconsideration of the grievance decision and a description of the procedure for submitting a request for a reconsideration of the grievance decision.

F) With every final adverse determination, the Company shall include a copy of the form prescribed by the Department of Insurance for the request of an external review

**Grievance Decision Reconsideration**

1) A grievance decision reconsideration is available to the Insured dissatisfied with the grievance review decision.

2) The Company may offer to the Insured or the Insured's authorized representative, if any, the opportunity for reconsideration of a final adverse determination where relevant medical information:

   a. was received too late to review within the 30 business day time limit; or

   b. was not received but is expected to become available within a reasonable time period following the written resolution.

3) When an Insured or the Insured's authorized representative, if any, chooses to request reconsideration, the Company must agree in writing to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the grievance. The time period for requesting external review shall begin to run on the date of the resolution of the reconsidered grievance.

**Expedited Grievance Review**

The Company shall provide for an expedited resolution concerning plan coverage or provision of immediate and urgently needed services, which shall include, but not be limited to:

1) A written resolution pursuant to 105 CMR 128.307 before an Insured's discharge from a hospital if the grievance is submitted by an Insured or the Insured's authorized representative while the Insured is an inpatient in a hospital.

2) Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the internal grievance process, within 48 hours (or earlier for durable medical equipment at the option of a Physician responsible for treatment or proposed treatment of the covered patient) of receipt of certification by said Physician that, in the Physician's opinion:

   a. the service or use of durable medical equipment at issue in grievance is Medically Necessary;

   b. a denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to the Insured; and

   c. such risk of serious harm is so immediate that the provision of such services of durable medical equipment should not await the outcome of the normal grievance process.

3) Provisions that require that, in the event a Physician exercises the option of automatic reversal earlier than 48 hours for durable medical equipment, the Physician must further certify as to the specific, immediate and severe harm that will result to the Insured absent action within the 48 hour time period.

### Expedited Process for Insured with Terminal Illness

1) When a grievance is submitted by an Insured with a terminal illness, or by the Insured's authorized representative on behalf of said Insured, a resolution shall be provided to the Insured or said authorized representative within five business days from the receipt of such grievance.
2) If the expedited review process affirms the denial of coverage or treatment to an Insured with a terminal illness, the Company shall provide the Insured or the Insured's authorized representative, if any, within five business days of the decision:
   a) a statement setting forth the specific medical and scientific reasons for denying coverage or treatment.
   b) a description of alternative treatment, services or supplies covered or provided by the Company, if any.
3) If the expedited review process affirms the denial of coverage or treatment to an Insured with a terminal illness, the Company shall allow the Insured or the Insured's authorized representative, if any, to request a conference.
   a) The conference shall be scheduled within ten days of receiving a request from an Insured; provided however that the conference shall be held within five business days of the request if the treating Physician determines, after consultation with the Company's medical consultant or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by the Company, would be materially reduced if not provided at the earliest possible date.
   b) At the conference, the Company shall permit attendance of the Insured, the authorized representatives of the Insured, if any, or both.
   c) At the conference, the Insured and/or the Insured's authorized representative, if any, and a Company representative who has authority to determine the disposition of the grievance shall review the information provided to the Insured under 105 CMR 128.310(B).
4) If the expedited review process set forth in 105 CMR 128.310 results in a final adverse determination, the written resolution will inform the Insured or the Insured's authorized representative of the opportunity to request an expedited external review pursuant to 105 CMR 128.401 and, if the review involves the termination of ongoing services, the opportunity to request continuation of services pursuant to 105 CMR 128.414.

### Failure to Meet Time Limits

A grievance not properly acted on by the Company within the required time limits required by 105 CMR 128.300 through 128.310 shall be deemed resolved in favor of the Insured. Time limits include any extensions made by mutual written agreement of the Insured or the Insured's authorized representative, if any, and the Company.

### Coverage or Treatment Pending Resolution of Internal Grievance

If a grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at the Company's expense through completion of the internal grievance process regardless of the final internal grievance decision, provided that the grievance is filed on a timely basis, based on the course of treatment. For the purposes of 105 CMR128.312, ongoing coverage or treatment includes only that medical care that, at the time it was initiated, was authorized by us, unless such care is provided pursuant to 105 CMR 128.309 (2) and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the Insured's contract for benefits.

## External Review

Any Insured or authorized representative of an Insured who is aggrieved by a final adverse determination issued by the Company may request an external review by filing a request in writing with the Office of Patient Protection within 4 months of the Insured's receipt of written notice of the final adverse determination.

If the external review involves the termination of ongoing services, the Insured may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to the Insured's health may result absent such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage shall be at the Company's expense regardless of the final external review determination.

The Department of Public Health, Office of Patient Protection, is available to assist consumers with insurance related problems and questions. An Insured seeking a review is responsible to pay a fee of $25.00 to the Office of Patient Protection which shall accompany the request for a review. The fee may be waived by the Office of Patient Protection if it determines that the payment of the fee would result in an extreme financial hardship to the Insured.

An Insured or the Insured's authorized representative, if any, may request to have his or her request for review processed as an expedited external review. Any request for an expedited external review shall contain a certification, in writing, from a Physician, that delay in the providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the Insured. Upon a finding that a serious and immediate threat to the Insured exists, the Office of Patient Protection shall qualify such request as eligible for an expedited external review.

Requests for review submitted by the Insured or the Insured's authorized representative shall:

a. be on a form prescribed by the Department;
b. include the signature of the Insured or the Insured's authorized representative consenting to the release of medical information;
c. include a copy of the written final adverse determination issued by us; and,
d. include the $25.00 fee required pursuant to 105 CMR 128.402.

You may inquire in writing or by telephone for information concerning an external review to:

The Association of Independent Colleges and Universities of Massachusetts

Department of Public Health

Office of Patient Protection

99 Chauncy Street

Boston, MA 02111

Toll-Free - 1-800-436-7757

FAX – 617-624-5046

www.state.ma.us/dph/opp/

The Company has a system for maintaining records of each grievance filed by an Insured or on his behalf, and response thereto, for a period of two years, which records shall be subject to inspection by the Commissioner of Insurance and the Department.

The Company provides the following information to the Office of Patient Protection no later than April 1st of each year:

1) a list of sources of independently published information assessing Insured's satisfaction and evaluating the quality of health care services offered by the Company;
2) the percentage of Physicians who voluntarily and involuntarily terminated participation contracts with the Company during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary Physician disenrollment;
3) the percentage of premium revenue expended by the Company for health care services provided to Insureds for the most recent year for which information is available;
4) a report detailing, for the previous calendar year, the total number of:
    a. filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution;
    b. external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.

The above information is available to the Insured or prospective insured from the Office of Patient Protection.

**Where to Send External Review Requests**

All types of External Review requests shall be submitted to the state insurance department at the following address:

The Association of Independent Colleges and Universities of Massachusetts

Department of Public Health

Office of Patient Protection

99 Chauncy Street

Boston, MA 02111

Toll-Free - 1-800-436-7757

FAX – 617-624-5046

www.state.ma.us/dph/opp/

**Questions Regarding Appeal Rights**

Contact Customer Service at 800-977-4698 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state consumer assistance program may be able to assist you at:

Health Care for All

30 Winter Street, Suite 1004

Boston, MA 02108

(800) 272-4232

www.massconsumerassistance.org

**Physician Profiling**

Physician profiling information for physicians licensed to practice in Massachusetts is available from the Massachusetts Board of Registration in Medicine.

## Utilization Review

You are not required to obtain pre-authorization of proposed treatments or participate in a prospective or concurrent utilization review program. Claims are reviewed retrospectively to determine that services provided were Medically Necessary. Claims that are identified by Our Claims Examiners as potentially not meeting Medical Necessity criteria are referred to our outside medical Review Organization for review before an Adverse Determination is made concerning the claim.

You may contact the Customer Service Department at 1-866-948-8472 if you have questions concerning the status of a claim.

## Utilization Review Program

The Company's Utilization Review Program consists of retrospective review of claims to determine that services and supplies were Medically Necessary. The Company does not require its Insureds to participate in a utilization review program that includes pre-authorization or concurrent review.

**Responsibility:**

The Special Investigations Unit is responsible for coordinating the Company's Utilization Review Program.

The Company coordinates certain functions with an outside certified Medical Review, as described below, and relies on the experience and qualifications of such Medical Review personnel when making utilization review determinations.

Physician Consulting Services (PCS), a UnitedHealthcare company, coordinates Medical Necessity review for the Company. PCS contracts with accredited External Review Organizations to perform Medical Necessity reviews for the Company in the State of Massachusetts.

**Review Process:**

The following procedures have been established to implement the Utilization Review Program:

1. The Company relies on the experience and training of its Claims Examiners to identify claims for services that may not be Medically Necessary as defined by the plan. Claims for services that are identified by the Claims Examiner as not being Medically Necessary are submitted to the Claims Supervisor for review.
2. If the Claims Supervisor determines that a claim is not Medically Necessary, then the claim is referred to the Claims Special Investigations Unit and Claims Vice President for review. Otherwise, the claim is processed according to the terms of the plan.
3. If the Claims Special Investigations Unit Manager determines that a claim is not Medically Necessary, then the claim is referred to the Company's Medical Consultant for review. Otherwise, the claim is processed according to the terms of the plan.
4. If the Medical Consultant determines that a claim may not be Medically Necessary, then the claim is referred to PCS, who obtains an outside Medical Review organization for utilization review before final determination. Otherwise, the claim is processed according to the terms of the plan.
5. a. If the Medical Review Organization agrees with the determination that services were not Medically Necessary, then the claim is declined. The Medical Review Organization provides the Company with its determination, and the Company is responsible for sending out the declination letter to the Insured and to the provider if applicable.

b. If the Medical Review Organization disagrees with the determination that services were not Medically Necessary (and therefore is of the opinion that services were Medically Necessary), then the claim is processed according to the terms of the plan.

Appeals:

The Company is the first point of contact if the Insured/provider wishes to request an informal explanation or review of their claim determination or to request an internal or external grievance review of their claim determination. Our Medical Consultant will be made available by telephone to discuss with practitioners determinations made based upon medical appropriateness. In addition, the Company will ensure that all resolutions will involve appropriate medical professionals (the Medical Consultant and/or the Medical Review Organization) and be in accordance with appropriate medical criteria.

The Insured, or the provider on behalf of the insured, may request an explanation/informal reconsideration through our Internal Inquiry Process. If the inquiry requires clinical review, or if they do not want to avail themselves of the Internal Inquiry Process, they may request an Internal Grievance Review. The Internal Grievance Review is a defined process which also allows for a Grievance Decision Reconsideration. If the Insured, or the provider on behalf of the insured, is not satisfied with the resolution of the Internal Grievance Review, they may request an external Grievance Review.

Oversight:

Oversight of the entire Utilization Review process will be performed at least annually by the Quality Improvement and Management Committee. This committee will review /update/approve the Utilization Management Program, including all processes and procedures, as a fully integrated part of the Company's quality improvement program.

The Utilization Review Program will require substantial involvement of a Medical Review Organization as selected by Physician Consulting Services (PCS). An agreement will be entered into with an URAC accredited (or other comparable accreditation) external Medical Review Organization outlining the expectations that the determinations will be based on the medical reviewers' expert opinion, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice and published clinical criteria from sources recognized in the area of specialty. Those medical standards of practice and published clinical criteria must be used by the Medical Review Organization in making its determinations.

In addition the Medical Review Organization will be required to comply with state insurance codes/regulations/statutes for the state that has authority for the case. We will require that the Medical Review Organization make available, on request, the UM criteria utilized to participating practitioners. We will also require that we be provided a copy of any information provided to the participating practitioners so that we may ensure compliance with this requirement.

We will monitor reviews that the Medical Review Organization has completed and the outcomes (including any appeals actions) of those reviews. Summary reports will be reviewed by the Quality Improvement and Management Committee appointed by the Company to determine if any concerns exist concerning decisions made by the Medical Review Organization (for example, patterns of adverse determination reversed upon appeal). In addition, the medical standards of practice and published clinical criteria used by the Medical Review Organization in making its determinations will be reviewed by the Utilization Review Committee to review/compare the decisions made by the Medical Review Organization.

### Clinical Guidelines:

The Company consults with UnitedHealthcare medical policy experts, appropriate providers, and other external experts, as needed, regarding the establishment of policies and procedures. The Company adheres to evidence-based clinical guidelines as determined by the Company's Medical Review Organization. The Company's clinical guidelines are available upon request.

## Quality Assurance

HPHC Insurance Company maintains a Quality Assurance Program. The goal of the Quality Assurance Program is to ensure the prevision of consistently excellent health care to Insured Persons, enabling them to maintain and improve their physical and behavioral health and well-being.

Examples of quality activities in place include a systematic review and re-review of the credentials of Preferred Providers and contracted facilities, as well as the development and dissemination of clinical standards and guidelines in areas such as preventive care, diabetes and asthma, medical records, appointment access, confidentiality, the appropriate use of drug therapies and new medical technologies, and the investigation and resolution of quality-of-care complaints registered by individuals.

## Online Access to Account Information

Insureds have online access to claims status, EOBs, correspondence and coverage information via My Account at my.uhcsr.com. Insureds can locate network providers from My Account. You may also access the most popular My Account features from your smartphone at our mobile site: my.uhcsr.com

If you don't already have an online account, simply select the "Create an Account" link from the home page at my.uhcsr.com. Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from my.uhcsr.com to access your account information.

## Claim Procedure

**In the event of Injury or Sickness, students should:**

1. Mail to the address below all medical and hospital bills along with the patient's name, and insured student's name, address, social security number and name of the university under which the student is insured. **A company claim form is not required for filing a claim.**
2. File claim within 30 days of Injury or first treatment of a Sickness. Bills should be received the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

**The Plan is Underwritten by:**

HPHC Insurance Company and
Administered by UnitedHealthcare **Student**Resources

**Submit all Claims or Inquiries to:**

HPHC Insurance Company
c/o UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-866-948-8472
Email: GKClaims@uhcsr.com

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

**This Certificate is based on Policy Number:**

**2012-1560-1**

**v12 NOC2**

## Gallagher Koster Complements

**These plans are not underwritten by HPHC Insurance Company, Inc. or any of it's affiliates**.

Exclusively from Gallagher Koster, enrolled students have access to the following menu of products. These plans are not underwritten by HPHC. More information is available at www.gallagherkoster.com/AnnaMaria.

### *EyeMed Vision Care*

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network offers access to over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You will receive a separate EyeMed ID card. There is no waiting period; you can take advantage of the savings immediately upon receipt of your EyeMed ID card. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% to 45% off regular retail pricing. In addition, you can receive discounts from 5% to 15% off laser correction surgery at some of the nation's most highly qualified laser correction surgeons. You can call 1-866-8EYEMED or go online to www.eyemedvisioncare.com and choose the Access network from the drop down network option.

### *Basix Dental Savings*

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides a wide range of dental services. It is important to understand the Dental Savings Program is not dental insurance. Basix contracts with dentists that agree to charge a negotiated fee to students covered under your Gallagher Koster plan. You must pay for the services received at the time of service to receive the negotiated rate.

Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on our website, www.basixstudent.com.
- Tell the dental office that you are an insured student and have to the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility. If the office - needs to check eligibility, call Gallagher Koster at 1-877-320-4347
- -Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

Full details of the program can be viewed at the website: www.basixstudent.com. Once at the home page, select the link for your school. You may also contact us via email from our website, or by telephone at 1-877-320-4347.

### *CampusFit*

College health is all about helping students develop healthy habits for a lifetime. To support your efforts, CampusFit "digitizes" knowledge from registered dieticians and certified fitness instructors to help teach and reinforce mainstream ideas about diet, nutrition, fitness and general wellness.

- The Energy Management section of the site allows a student to easily assess how much energy they are consuming, and expending on a daily basis. It also displays the results in the context of the Food Pyramid so students can see how to improve their food choices.
- The Fitness Works section has dozens of downloadable mp3 files and written exercise routines to help students get more active. Want to run your first 5K? We've got a nine week, step-by-step plan to get you there.
- The Wellness Support section has downloadable mp3 files for guided imagery relaxation, and dozens of recordings to reinforce fundamental diet and nutrition ideas – we've even got a 20 minute discussion on the "Freshman 15".

CampusFit is available at no cost to students. To access CampusFit, go to www.gallagherkoster.com/AnnaMaria.

## QUESTIONS? NEED MORE INFORMATION?

For general information on benefits, eligibility and enrollment, student ID Cards, or service issues, please contact:

**Gallagher Koster**
500 Victory Road
Quincy, MA 02171
1-877-320-4347
Email: www.gallagherkoster.com/AnnaMaria

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call Gallagher Koster to verify eligibility.

UnitedHealthcare®
A UnitedHealth Group Company

POLICY NUMBER: 2012-1560-1

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC #2 (1/3/13)
1. Added the following text to exclusion #37 (except surgery for morbid obesity,).