Read Your Certificate Carefully

2016–2017 Student Injury and Sickness Insurance Plan

Designed Especially for the Students attending

Northfield Mount Hermon School Massachusetts

Non-Renewable Term Insurance. Limited Benefit Plan. Please Read Carefully.

06-BR-MA-PPO (Rev 09) 20-2182-11

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic 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 nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-888-455-9402 or by visiting us at www.uhcsr.com.

Eligibility

All Domestic students registered for credit courses are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished.

All International students registered for credit courses are automatically enrolled in this insurance Plan at registration.

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

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 20, 2016. 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., June 20, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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

The Policy is a Non-Renewable Term Policy.

Extension of Benefits after Termination

The coverage provided under this 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 as long 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.

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 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.

Premium Rate

School Year **(8/20/16 – 6/20/17)** **$1,750.00**

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

Involuntary Disenrollment Rate

The involuntary disenrollment rate for Insureds in Massachusetts for UnitedHealthCare Insurance Company for 2015 was 0%.

Complaint Resolution

Insured Persons, Preferred Providers, Out-of-Network Providers or their representatives with questions or complaints may call the Customer Service Department at 1-888-455-9402. 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.

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.

Preferred Provider Information

The **UnitedHealthcare Options PPO 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 UnitedHealthcare Options PPO.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

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

"Out-of-Network" providers have not agreed to any prearranged fee schedules. You may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are your responsibility.

<u>**Inpatient Hospital Expenses**</u>

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be covered at 100% up to any limits specified in the Schedule of Benefits. Call 1-888-455-9402 for information about Preferred Hospitals.

OUT OF NETWORK HOSPITALS - If care is provided at a Hospital that is not a Preferred Provider, your eligible inpatient hospital expenses will be paid according to the benefit limits in the Schedule of Medical Expense Benefits.

<u>**Outpatient Hospital Expenses**</u>

Preferred Providers may discount your bills for outpatient hospital expenses. Benefits are paid according to the Schedule of Benefits. You pay any amount that exceeds the benefits shown on the Schedule of Benefits, up to the Preferred Allowance.

<u>**Professional & Other Expenses**</u>

Benefits for Covered Medical Expenses provided by Preferred Providers will be paid at 100% of Preferred Allowance, 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.

Schedule of Medical Expense Benefits

Injury and Sickness Benefits

Maximum Benefit - Unlimited

Deductible	$0
Preferred Provider Coinsurance	100% except as noted below
Out-of Network Coinsurance	80% except as noted below

The Policy provides benefits as shown below for loss incurred by an Insured due to a covered Injury or Sickness.

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 Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. (See Medical Emergency Treatment on Page 17 for additional information.) In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Usual and Customary Charges are based on data provided by FAIR Health, Inc. using the 90th percentile based on location of provider.

If care is received at the O'Connor Student Health Center, Covered Medical Expenses will be payable at 100%.

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

Inpatient	Preferred Provider	Out-of-Network Provider
Room and Board Expense, daily semi-private room rate; general nursing care provided by the Hospital.	Preferred Allowance	Usual and Customary Charges
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.	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Physiotherapy	Preferred Allowance	Usual and Customary Charges
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. 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.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon	Preferred Allowance	Usual and Customary Charges
Anesthetist, professional services administered in connection with inpatient surgery.	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services, private duty nursing care.	Preferred Allowance	Usual and Customary Charges
Physician's Visits, benefits do not apply when related to surgery.	Preferred Allowance	Usual and Customary Charges
Pre-Admission Testing, payable within 7 working days prior to admission.	Paid under Hospital Miscellaneous Expenses	Paid under Hospital Miscellaneous Expenses

Inpatient	Preferred Provider	Out-of-Network Provider
Mental Disorders, coverage continues beyond the age of 19 if still attending school. (60 days maximum)	See Benefits for Treatment of Mental Disorders	See Benefits for Treatment of Mental Disorders

Outpatient	Preferred Provider	Out-of-Network Provider
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. 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.	Preferred Allowance	Usual and Customary Charges
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.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon	Preferred Allowance	Usual and Customary Charges
Anesthetist, professional services administered in connection with outpatient surgery.	Preferred Allowance	Usual and Customary Charges
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	Preferred Allowance	Usual and Customary Charges
Physiotherapy (60 visits maximum Per Policy Year)	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses, benefits will be paid for the attending Physician's charges, x-rays, laboratory procedures, injections, the use of the emergency and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	Preferred Allowance	100% of Usual and Customary Charges
Diagnostic X-ray Services	Preferred Allowance	Usual and Customary Charges
Laboratory Services Benefits include titers related to immunizations and QuantiFERON test.	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-rays and Lab Procedures.	Preferred Allowance	Usual and Customary Charges
Injections, when administered in the Physician's office and charged on the Physician's statement.	Preferred Allowance	Usual and Customary Charges
Prescription Drugs, and medicines lawfully obtainable only upon written prescription of a Physician.	UnitedHealthcare Pharmacy $0 copay per prescription for Tier 1 $0 copay per prescription for Tier 2 $0 copay per prescription for Tier 3 up to a 31 day supply per prescription	Usual and Customary Charges $0 Deductible per prescription up to a 31 day supply per prescription

Outpatient	Preferred Provider	Out-of-Network Provider
Mental Disorders, Coverage continues beyond the age of 19 if still attending school. Outpatient care 24 visit maximum Per Policy Year does not apply, Benefits are paid same as any other Sickness.	See Benefits for Treatment of Mental Disorders	See Benefits for Treatment of Mental Disorders

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	Preferred Allowance	Usual and Customary Charges
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	Preferred Allowance	Usual and Customary Charges
Alcoholism/Drug Abuse (Substance Abuse)	See Benefits for Treatment of Mental Disorders	See Benefits for Treatment of Mental Disorders
Consultant Physician Fees, when requested and approved by the attending Physician.	Preferred Allowance	Usual and Customary Charges
Dental Treatment, made necessary by Injury to Sound, Natural Teeth.	Preferred Allowance	Usual and Customary Charges
Maternity	See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care	See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Interscholastic Sports	Preferred Allowance	Usual and Customary Charges
Home Health Care	See Benefits for Home Health Care	See Benefits for Home Health Care
Hospital Outpatient Department Visit, Benefits are limited to the facility/clinic charges billed by the Hospital.	Preferred Allowance	Usual and Customary Charges
Preventive Care Services, preventive care benefits are based on guidelines from UnitedHealthcare, the U.S. Preventive Services Task Force and recommendations of the National Immunizations Program of the Centers for Disease Control Prevention, except as specifically provided in the Mandated Benefit.	Preferred Allowance	Usual and Customary Charges
Urgent Care Clinic Fee, benefits are limited to the Urgent Care Clinic fee billed by the Urgent Care Clinic/Hospital. All other services rendered during the visit are payable as specified in the Schedule of Benefits.	Preferred Allowance	Usual and Customary Charges
Cytologic Screening, annual cytological screening. Benefits begin at age 13.	Preferred Allowance	Usual and Customary Charges

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare 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 call1-855-828-7716 for the most up-to-date tier status.

$0 copay per prescription order or refill for tier 1 Prescription Drug up to a 31 day supply.

$0 copay per prescription order or refill for tier 2 Prescription Drug up to a 31 day supply.

$0 copay per prescription order or refill for tier 3 Prescription Drug up to a 31 day supply.

Specialty Prescription Drugs – if you require Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

Designated Pharmacies – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

Please present your ID card to the network pharmacy when the prescription is filled.

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 network pharmacies, please call 1-855-828-7716.

When prescriptions are filled at pharmacies outside the network, the Insured must pay for the prescriptions out-of-pocket and submit the receipts for reimbursement to UnitedHealthcare **Student**Resources, P.O. Box 809025, Dallas, TX 75380-9025. See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.

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.

6. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
7. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

Definitions

Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

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 1-855-828-7716.

Specialty Prescription Drug Product means Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products through the Internet at www.uhcsr.com or call Customer Service at 1-855-828-7716.

Therapeutically Equivalent means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity

Mandated Benefits

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 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.

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 the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year.

"**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 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.

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

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

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 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 $350.00 per Policy Year.

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 TREATMENT OF DIABETES

Benefits will 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, co-payments 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 TREATMENT OF SPEECH, HEARING AND LANGUAGE DISORDERS

Benefits will be paid the same as any other 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 OFF-LABEL DRUG USE

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,
12. substance abuse disorders, and
13. autism.

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 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 the Insured Person’s nineteenth birthday until said course of treatment, as specified in such 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 during each 12 month period but shall never exceed:

1. 60 days of inpatient treatment; and
2. 24 outpatient visits.

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 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 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 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.

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 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.

Definitions

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. The term "complication of pregnancy" includes non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; hyperemesis gravidarum; and, pre-eclampsia.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) 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.

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 per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

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 confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is: 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; and 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.

INSURED PERSON means the Named Insured. 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; or
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:

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; and,
5. The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 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 Hospital Confinement.

MENTAL DISORDER means a Sickness that is a mental, emotional or behavioral disorder. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association 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 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.

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 Insured 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. Physician's 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: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

PRESCRIPTION DRUGS means: 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.

USUAL AND CUSTOMARY CHARGES means 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 where service is rendered. 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. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn children;

2. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;

3. Dental treatment, except for accidental Injury to Sound, Natural Teeth;

4. Elective Surgery or Elective Treatment;

5. Elective abortion;

6. 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 disease process;

7. Hearing examinations or hearing aids; or other treatment for hearing defects and problems, except as specifically provided in the policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

8. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

9. Investigational services;

10. Organ transplants, including organ donation;

11. Participation in a riot or civil disorder; commission of or attempt to commit a felony;

12. 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 policy;

13. Routine Newborn Infant Care, well-baby nursery and related Physician charges, except as specifically provided in the Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care;

14. Services provided normally without charge by the Health Service of the Policyholder;

15. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and

16. 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).

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.

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. See the Pre-Admission Notification Section for instructions on informing the Company of your expected Hospitalization or following emergency admission.

Managed Care Information Provisions

Provider Directories

Provider Directories for the UnitedHealthcare Options PPO Network may be obtained:

a) by calling UnitedHealthcare **Student**Resources at 1-888-455-9402;
b) at the Student Health Center; or
c) by logging on to the website at www.studentresources.com for information.

In addition, UnitedHealthcare Options PPO directories may be obtained by: logging on to the website at www.myuhc.com.

Service Area Description

All counties in Massachusetts are included in the UnitedHealthcare Options PPO 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

You, the Insured, will be notified in writing by us if a claim or any part of your 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 you have a complaint about your claim denial, you may call our Member Services telephone number 1-888-455-9402 for further explanation to informally resolve your complaint or contact the consumer assistance toll-free number maintained by the Office of Patient Protection at 1-800-436-7757. If you are not satisfied with our explanation of why the claim was denied, you, your authorized representative or provider may request an internal review of the claim denial. The following is our internal inquiry process:

1. You, the Insured, must request a benefit review within 60 days after the date that you receive the notice denying your claim. This will be an informal reconsideration review process of your claim by a Claims Supervisor. The Insured may not attend this review.

2. A decision will be made by the Claims Supervisor, within 3 days after the receipt of your request for review or the date all information required from the Insured is received.

3. We 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 carrier, 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. We have a system for maintaining records for a period of two years of each inquiry communicated by an Insured or on his or her 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 info@uhcsr.com or by calling our Member Services telephone number 1-800-767-0700 by the Insured or his/her provider for consideration by the grievance reviewer. An oral grievance made by the Insured or the authorized representative shall be reduced to writing by us and a copy thereof forwarded to the Insured by us 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 us.

2. Within 15 business days after we receive your request for an internal grievance review, we must provide you with the name, address and telephone number of the grievance coordinator and information on how to submit written material, except where an oral grievance has been reduced to writing by us or this time period is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and us.

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 us authorizing the release of medical and treatment information relevant to the grievance to us, 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 us and under our control. We shall request said authorization from the Insured when necessary for requests reduced to writing by us 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 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, we may, in our 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 carrier 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 us. 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 Insurer'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 carrier, 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.

Grievance Decision Reconsideration

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

2. We may offer to the Insured or the Insured's authorized representative, if any, the opportunity for reconsideration of our 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, we 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

We shall provide for an expedited resolution concerning our 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, we 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 and
   b. a description of alternative treatment, services or supplies covered or provided by the carrier, if any.

3. If the expedited review process affirms the denial of coverage or treatment to an Insured with a terminal illness, we 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 our 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 us, would be materially reduced if not provided at the earliest possible date.
   b. At the conference, we 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 our 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 us within the 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 us.

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 our 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 us may request an external review by filing a request in writing with the Office of Patient Protection within 45 days 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 our 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 Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
250 Washington Street, 2nd Floor
Boston, MA 02108
Toll-Free - 1-800-436-7757
FAX 617-624-5046
www.state.ma.us/dph/opp/

We have a system for maintaining records of each inquiry communicated 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.

We provide the following information to the Office of Patient Protection no later than May 15 of each year:

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

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 not meeting Medical Necessity criteria are referred to Our Medical Director for review. If in the Medical Director's opinion the services are not Medically Necessary, the claim is referred to an outside Utilization Review Organization for review before an Adverse Determination is made concerning the claim.

You may contact the Customer Service Department at 1-888-455-9402 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 delegates certain functions to an outside certified Medical Review, as described below, and relies on the experience and qualifications of such Medical Review personnel to make final utilization review determinations.

An example of a URO used by the Company in the State of Massachusetts is AllMed, Inc. AllMed is accredited by the American Accreditation HealthCare Commission / URAC.

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 is not Medically Necessary, then the claim is referred to an outside certified Medical Review Organization for review and 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/providers may request an explanation/informal reconsideration through our Internal Inquiry Process. If the Insured/provider is not satisfied with the resolution through the Internal Inquiry Process, 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/provider 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 Utilization Review Committee. This committee will review/update/approve the Utilization Management Program, including all processes and procedures.

The Utilization Review Program will require substantial involvement of a Medical Review Organization as selected by the Utilization Review Committee. A delegation agreement will be entered into with an URAC accredited (or other comparable accreditation) 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 require a semiannual report of the reviews that the Medical Review Organization has completed and the outcomes (including any appeals actions) of those reviews. These 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 appropriate providers, and other external experts, as needed, regarding the establishment of policies and procedures. The Company adheres to standard expert published criteria as decided by the Company's Independent Review Organization. The Company adheres to clinical guidelines determined by its external Independent Review Organization Physician.

Quality Assurance

In order to fulfill the goals and objectives of the Quality Improvement and Management Program (QIMP) and effectively use resources, the program is integrated into all Company activities. This includes, but is not limited to, interactions with United Behavioral Health, Network management, National Credentialing Center, and Pharmaceutical Solutions/Medco. The primary focus of QIMP activities relates to those policies administered under the regulatory authority of the state of Massachusetts. The QIMP addresses areas of Quality Improvement, Utilization Management and Credentialing as they apply to the Company's unique line of business. Generalizable findings may be applied across the company. Special attention is given to high volume, high risk areas of service for our population. Health promotion and health management activities are also a part of the QIMP Program.

Quality Improvement and Management Program

The Company contracts with outside PPO Networks for access to providers by the Company's Insureds in the Commonwealth of Massachusetts.

The Company has accountability for the quality of the administration of healthcare services through contracts with Preferred Provider Organizations (PPOs). It is the responsibility of the Company to ensure that quality management and improvement is quantified and measured according to the Company's goals and objectives in relation to the quality of services. The establishment and implementation of a Quality Improvement and Management Program Policy and Procedures will ensure that uniform standards are practiced and adhered to according to contractual obligations and standards adopted by the Company.

The Company contracts with outside PPO Networks for access to providers and practitioners by the Company's Insureds. The Company delegates the contracting of healthcare providers and practitioners to the PPO Network. The Company's goal is to ensure that its Insureds/enrollees have access to an adequate number of PPO Network providers and practitioners on a timely basis.

The Company delegates the functions of selection and credentialing / recredentialing of PPO Network providers and practitioners to the PPO Network. The Company monitors the PPO Network through an auditing process that reviews criteria established by the Company.

Program Description:

The Quality Improvement and Management Program (QIMP) includes the following components:

- Promote and incorporate quality into the Company's organizational structure and processes.
  - Facilitate a partnership between customers, practitioners, providers and staff for the continuous improvement of quality health care delivery.
  - Continuously improve communication and education in support of these efforts.
- Provide effective monitoring and evaluation of patient care and services provided by contracted practitioners/providers compared to the requirements of evidence based medicine to ensure the Company is positively perceived by customers and health care professionals.
  - Evaluate and disseminate clinical and preventive practice guidelines.
  - Monitor performance of practitioners and providers against Evidence-based Medicine.
  - Develop guidelines for quality improvement activities (e.g. access and availability, credentialing/recredentialing, peer review, etc.).
  - Survey customers' and practitioners' satisfaction with the quality of care and services provided.
  - Develop, define, and maintain data systems to support quality improvement activities.
- Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.
  - Identify and monitor important aspects, problems, and concerns about health care services provided to customers.
  - Implement and conduct a comprehensive Quality Improvement Program.
- Coordinate quality improvement, risk management and patient safety activities.
  - Aggregate and use data to develop quality improvement activities.
  - Provide a regular means by which risk management is included in the development of quality improvement initiatives.
  - Identify, develop and monitor key aspects of patient safety
- Maintain compliance with local, state and federal regulatory requirements and accreditation standards.
  - Monitor compliance with regulatory requirements for quality improvement and risk management opportunities and respond as needed.
  - Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.

Selection and Monitoring of PPO Network:

Procedures to select and monitor the adequacy and quality of the PPO Networks, including those for behavioral health services, with which the Company contracts must be established and maintained.

Initial Selection of PPO Network, including behavioral health services, and determination of Network Adequacy:

The Company's Managed Care Department has responsibility for contracting with PPO Networks. The Company applies the following criteria to the PPO upon selection:

- The PPO must operate without discrimination.
- The PPO must conduct business in accordance with federal, state and local statutes, regulations and ordinances, and in compliance with all applicable Company standards.
- Adherence by the PPO to the Company's Delegation of Credentialing Policy and Procedure.
- Adherence by the PPO Network to the Company's Quality Improvement and Management Policy and Procedure.
- Adherence to all other Company policies and procedures applicable to the Insured's access to adequate and efficient health services.
- Contract management oversight that includes annual performance evaluations, outcome management, data collection, review of system capabilities for data extraction, gap analysis, review of PPO's established guidelines and measurement relating to clinical outcomes, review of Insured's complaints, review of adherence to Company's policies and procedures for delegation, review of data source obtained for measurement, and review of PPO's corrective action plan.
- Review of documentation regarding the PPO Network's patient safety program.

Monitoring Activities for PPO Networks:

The Company delegates credentialing and recredentialing activities related to the providers and practitioners to the PPO Network. The Company's role in the QIMP includes monitoring and oversight practices described below. The Company must maintain a policy and procedure regarding the review process of the contracted PPO Networks.

The Company must complete a review of the PPO Network with which it contracts on an annual basis using the processes identified in its policy and procedure regarding the review process of the contracted PPO Networks. The results of the annual reviews will be documented by the Managed Care Department and reviewed with the QIMP Committee.

The quality of health care, including behavioral health services, received by enrollees from PPO Networks with which the Company contracts will be monitored by the Company through the following methods:

- Results of the quality management program activities of the PPO Network will be reviewed by the Company. The review of the PPO Network includes the following with respect to quality management:
  a. Review of the written criteria to assure quality of providers and practitioners and schedule for recredentialing of Hospitals, Physicians and ancillary and other providers;
  b. Review of software and hardware capabilities, focusing in part on quality assurance tracking software and reports;
  c. Review of established guidelines or measures relating to clinical guidelines and outcomes measures;
  d. Review of complaint files.
- Review and analysis of complaints received that relate to the quality of health care provided by a Network provider or practitioner. Patterns of complaints will be reported to the PPO Network.
- Complaints and grievances that involve solely a quality of care issue will be referred to the PPO Network for review and resolution. The Company will implement a procedure to follow-up on complaints and grievances that are referred to the PPO Network as well as to monitor the PPO Network's grievance process. Any complaints or grievances that relate to a claims administration issue will be processed pursuant to the Company's Grievance procedures.
- Surveys may be used to collect data from Insureds/enrollees regarding the quality of health care services received from PPO Network providers and practitioners. Information collected through this mechanism will be provided to the PPO Network, without specific identifying information as to the claimant / patient.

These processes and actions will help to ensure the safety of patients who access the providers and practitioners in the PPO Network. Additional processes to ensure patient safety may be adopted through the QIMP annual work plan.

If deficiencies are noted as a result of the Company's monitoring and oversight activities, the Company will notify the PPO Network of the deficiencies and, at the Company's discretion, request a corrective action plan from the PPO Network. The Company will re-evaluate the PPO Network to determine if the delegation of duties to the PPO Network is being performed in accordance with applicable Company standards.

Availability and Accessibility Standards:

When developing availability standards, the Company must take into account the assessed special and cultural needs and preferences of its insured population. This may be determined through the following means:

- Surveys of its insured population;
- Reviews of demographic data;
- Other methods as may be determined and documented through the QIMP work plan.

The Company must maintain established standards for the number and geographic distribution of key specialty care practitioners.

When developing accessibility standards, the Company must adopt mechanisms to ensure the accessibility of primary care services, urgent care services, behavioral health services, and member services. Accessibility standards must include acceptable time frames for an Insured to access provider services and telephone services as well as minimum requirements for hours of operation and service availability for behavioral health care.

Availability and accessibility standards must be monitored to ensure that the Company's standards are being met on an annual basis. This may be accomplished through the following means:

- Surveys to its insured population;
- Analysis of the number of providers and practitioners to the number of Insureds in a geographic area;
- Review of Insured's complaints;
- Analysis of the telephone abandonment rate to the Customer Care Department;
- Review of data that may available from the PPO Network;
- Other acceptable methods as may be determined and approved by the QIMP Committee.

As a general rule, the Company would expect a network provider to be available to an Insured within a 50-mile radius of the Insured's residence. If a network provider is not available within a reasonable distance of the Insured's home, the Company will agree to provide benefits to an out-of-network provider with benefits payable at the in-network provider level. These situations are reviewed on a case-by-case basis.

Access:

The Company offers its PPO plans to individuals in urban, suburban and rural communities. The Company has adopted the following standards to address accessibility based on driving distance to providers:

HEALTH STANDARDS

Urban Areas:

At least one family practitioner or general practitioner (PCP) within 10 miles of 80% of the maximum population AND at least one OB/GYN and one pediatrician within 10 miles of 80% of the maximum population. 65% of a predetermined listing of specialty types determine the specialty physician contracted within 30 miles except for chiropractic medicine, physical therapy, clinical psychology, clinical social work, ambulatory surgery centers, laboratories, and radiology imaging centers which are contracted at 70% of supply. 50% of hospitals are contracted with 75% of the maximum population with access within 10 miles of general acute care.

Suburban Areas:

At least one family practitioner or general practitioner within 20 miles of 75% of the maximum population. 55% of a predetermined listing of specialty types determine the specialty physician contracted within 40 miles except for chiropractic medicine, physical therapy, clinical psychology, clinical social work, ambulatory surgery centers, laboratories, and radiology imaging centers which are contracted at 60% of supply. 60% of hospitals are contracted with 75% of the maximum population with access within 30 miles of general acute care.

Rural Areas:

At least one family practitioner or general practitioner within 50 miles of 65% of the maximum population. 45% of a predetermined listing of specialty types determine the specialty physician contracted within 50 miles, except for chiropractic medicine, physical therapy, clinical psychology, clinical social work, ambulatory surgery centers, laboratories, and radiology imaging centers which are contracted at 50% of supply. A choice of at least one general acute care hospital is contracted with 65% of the maximum population with access within 50 miles of general acute care.

BEHAVIORAL HEALTH STANDARDS

Urban Areas:

One therapist and one Hospital within 15 miles of Insured's residence.

Suburban Areas:

One therapist and one Hospital within 25 miles of Insured's residence.

Rural Areas:

One therapist and one Hospital within 100 miles of Insured's residence.
The Company will review cases in which an Insured is not reasonably able to access a network provider on a case-by-case basis. In a situation where an Insured cannot reasonably access a network provider due to access-related issues, benefits for Covered Medical Expenses provided by a non-network provider will be provided at the in-network level of benefits.

The Company has adopted the following standards to address appointment time accessibility for both urban and rural areas:

Appointment Times

Accessibility Type	Primary Care Standard	Specialist Standard
Urgent Appointment	Seen on same day	Seen within 2 days
Non-Urgent Appointment	Seen within 7 days	Seen within 14 days
Routine Appointment	Seen within 14 days	Seen within 30 days

The Company will monitor these standards through customer service calls and complaints.

Telephone Access:

The following telephone access standards exist in the Company's Service Center:

- Telephones must be answered within 60 seconds. This standard is monitored by the Customer Service Center management on a daily basis. Results of monitoring are reported to the Company's senior management on a weekly basis.
- The goal for abandoned phones calls is no more than 4%. This standard is monitored by the Customer Service Center management on a daily basis. Results of monitoring are reported to the Company's senior management on a daily basis.

Behavioral Health Care:

The Company's health benefit plans must meet the mandated benefits for mental health care in Massachusetts as required by law. The Company's Quality Improvement and Management Program will operate in the same manner for persons with behavioral health care issues (that are covered under the terms of the health benefit plan) as it does with respect to any other condition.

UnitedHealthcare Global: Global Emergency Services

If you are a member insured with this insurance plan, you are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

International students: you are eligible to receive UnitedHealthcare Global services worldwide, except in your home country.

Domestic students: you are eligible for UnitedHealthcare Global services 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.

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 services must be arranged and provided by UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to $5,000.00 payment
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit www.uhcsr.com/UHCGlobal for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.

To access services please call:
(800) 527-0218 Toll-free within the United States
(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at assistance@UHCGlobal.com.

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

- Caller's name, telephone and (if possible) fax number, and relationship to the patient;
- Patient's name, age, sex, and UnitedHealthcare Global ID Number as listed on your Medical ID Card;
- Description of the patient's condition;
- Name, location, and telephone number of hospital, if applicable;
- Name and telephone number of the attending physician; and
- Information of where the physician can be immediately reached.

UnitedHealthcare Global 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 UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted.

Claim Procedures for Injury and Sickness Benefits

Students should:

1. Secure a Company claim form from the Student Health Service or from the address below, fill out the form completely, attach all medical and hospital bills and mail to the address below.

2. File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by 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.

3. Benefits will be paid within forty-five (45) days of receipt of a claim. If payment is not made, the Company will notify the Insured in writing specifying the reasons for the nonpayment or what additional documentation is necessary for payment of the claim. If the Company fails to comply with the terms of this provision, in addition to any benefits payable, interest on such benefits will accrue beginning forty-five (45) days after the Company's receipt of the claim at a rate of one and one-half (1½) percent per month, not to exceed eighteen (18) percent per year. The interest payments shall not apply to a claim which the Company is investigating because of suspected fraud.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-888-455-9402

Sales/Marketing Service:

UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702

Please keep this Certificate as a general summary of the insurance. The Master Policy contains all of the provisions, limitations, 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:
2016-2182-11