Harvard Pilgrim Health Care

2012-2013 Student Injury and Sickness Insurance Plan

Limited Benefit Plan. Please Read Carefully.

Designed especially for the students of:

Bates College

Lewiston, Maine

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

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

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $100,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-977-4698. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

Eligibility

All students enrolled in 3 or more classes are required to purchase the plan on a hard waiver basis. When the student's current insurance is not a domestic or US-based company, the student will be required to remain enrolled on a mandatory basis..

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PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the Named Insured actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

STATEMENTS IN APPLICATIONS: All statements made by the Policyholder shall be deemed representations and not warranties.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: If the Named Insured requests in writing not later than the time of filing proofs of such loss, all or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company may have a right of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Company may not exercise this right of recovery without the prior written consent of the Insured. Allowances will be made for legal fees, court costs and compromise settlements.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

GUARANTEED RENEWABILITY: This policy is guaranteed renewable for the policyholder and Insureds except (a) when the policyholder fails to pay premiums in accordance with the terms of the policy; (b) for fraud or intentional misrepresentation of material fact by the policyholder; (c) for fraud or intentional misrepresentation of material fact on the part of the Insured or Insured's representative; or (d) when the Insured no longer meets the Eligibility requirements of the policy.

PART III
DEFINITIONS

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

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a

classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

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.

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 and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

INJURY means bodily injury which is all of the following:

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

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

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

INSURED PERSON means: the Named Insured;

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

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

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

1) Death.
2) Placement of the Insured's health in jeopardy.
3) Serious impairment of bodily functions.
4) Serious dysfunction of any body organ or part.
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICAL NECESSITY means health care services or products provided to an Insured for the purpose of preventing, diagnosing or treating an Injury or Sickness or the symptoms of an Injury or Sickness in a manner that is:

1) Consistent with generally accepted standards of medical practice;
2) Clinically appropriate in terms of type, frequency, extent, site and duration;
3) Demonstrated through scientific evidence to be effective in improving health outcomes;
4) Representative of “best practices” in the medical profession; and,
5) Not primarily for the convenience of the Insured, or the Insured's Physician.

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

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

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

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

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

NEWBORN INFANT means any child born of an Insured 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.

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

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

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

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

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

PRE-EXISTING CONDITION means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under the policy.

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

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

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates 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.

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Named Insured unable to actively attend class. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

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

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a reasonable charge which is : 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges. The Insured may be billed for any charges which exceed the Usual and Customary Charges. The Insured may call the Company at 1-800-977-4698 for the maximum Usual and Customary Charge for a specified service.

PART IV
EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Totally Disabled 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 6 months 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.

PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
BATES COLLEGE - STUDENT PLAN
2012-1295-1
INJURY AND SICKNESS BENEFITS

Maximum Benefit	**$100,000 (Per Insured Person) (Per Policy Year)**
Deductible Preferred Providers	**$100 (Per Insured Person, Per Policy Year)**
Deductible Out of Network	**$250 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Providers	**80% except as noted below**
Coinsurance Out of Network	**60% except as noted below**
Out-of-Pocket Maximum	**$5,000 (For Each Injury or Sickness)**

The Preferred Providers for this plan is the HPHC Insurance Company Network.

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

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

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated.

Inpatient	**Preferred Provider**	**Out-of-Network Provider**
Room & Board:	Preferred Allowance	Usual and Customary Charges
Intensive Care:	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous:	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care:	Paid as any other Sickness	Paid as any other Sickness
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
Surgery:	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing:	Preferred Allowance	Usual and Customary Charges

Outpatient	**Preferred Provider**	**Out-of-Network Provider**
Surgery:	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous:	Preferred Allowance	Usual and Customary Charges
(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	100% of Preferred Allowance $10 Copay per visit	Usual and Customary Charges
Physiotherapy:	Paid under Physician's Visits	Paid under Physician's Visits

Outpatient	Preferred Provider	Out-of-Network Provider
Medical Emergency:	Preferred Allowance $50 Copay per visit	80% of Usual and Customary Charges $50 Deductible per visit
(The Copay/per visit Deductible will be waived if admitted to the Hospital.)		
X-rays:	Note Below *100% of Preferred Allowance for the first $500, then 80% thereafter*	Usual and Customary Charges
Radiation Therapy:	Preferred Allowance	Usual and Customary Charges
Laboratory:	Note Below *100% of Preferred Allowance for the first $500, then 80% thereafter*	Usual and Customary Charges
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges
Chemotherapy:	Preferred Allowance	Usual and Customary Charges
***Prescription Drugs:**	UnitedHealthcare Network Pharmacy (UHPS) $10 Copay per prescription for Tier 1 $25 Copay per prescription for Tier 2 up to a 31-day supply per prescription	No Benefits

Other	Preferred Provider	Out-of-Network Provider
Ambulance:	80% of Preferred Allowance	80% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum are not included in the $100,000 Maximum Benefit.)		
Consultant:	No Benefits	No Benefits
Dental:	100% of Preferred Allowance	100% of Usual and Customary Charges
($250 maximum per tooth) (Benefits paid on Injury to Sound, Natural Teeth only. Benefits are not subject to the $100,000 Maximum Benefit.)		
Maternity:	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion:	100% of Preferred Allowance	100% of Usual and Customary Charges
($500 maximum Per Policy Year) (Elective Abortion benefits are not subject to the $100,000 Maximum Benefit.)		
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Repatriation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
Medical Evacuation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
AD&D:	No Benefits	No Benefits
Home Health Care:	See Benefits for Home Health Care	See Benefits for Home Health Care
Learning Disability Testing:	Preferred Allowance	Usual and Customary Charges
(Diagnostic Testing & Treatment for Learning Disabilitites)		
Preventive Care Services:	100% of Preferred Allowance *(No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.)*	Usual and Customary Charges
Diabetes Services:	Paid as any other Sickness	Paid as any other Sickness
(See Benefits for Diabetes Treatment)		
Mental Illness Treatment:	Paid as any other Sickness	Paid as any other Sickness
(See Benefits for Mental Illness and Substance Use Disorder.)		
Reconstructive Surgery Following Mastectomy:	Paid as any other Sickness	Paid as any other Sickness
(See Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery.)		
Substance Use Disorder Treatment:	Paid as any other Sickness	Paid as any other Sickness
(See Benefits for Mental Illness and Substance Use Disorder.)		

MAJOR MEDICAL

Maximum Benefit No Benefits

CATASTROPHIC MEDICAL

Maximum Benefit No Benefits

SHC Referral Required: Yes ( ) No (X) **Continuation Permitted:** Yes ( ) No (X)

( ) 52 Week Benefit Period or **(X) Extension of Benefits**

***Pre Admission Notification:** Yes (X) No ( )

Other Insurance: (X) *Coordination of Benefits ( ) Excess Motor Vehicle ( ) Primary Insurance

*If benefit is designated, see endorsement attached.

PART VI
PREFERRED PROVIDER INFORMATION

"Network and **Preferred Providers"** are the Physicians, Hospitals and other health care providers who have contracted with HPHC Insurance Company to provide specific medical care at negotiated prices. Preferred Providers are specially designated Physicians, Hospitals, and other health care providers who are available at lower out-of-pocket cost to an Insured than other Network Providers or Out of Network providers. Preferred Providers in the local school area are:

HPHC Insurance Company Network.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-977-4698 and/or by asking the provider when making an appointment for services.

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

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

"**Network Area**" means: 1) for primary care services, providers available within 30 minutes travel time and 2) for specialty care and hospital services, providers available within 60 minutes travel time by automobile of the local school campus the Named Insured is attending.

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

Inpatient Expenses

PREFERRED PROVIDERS:– Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include HPHC Insurance Company Network United Behavioral Health (UBH) facilities. Call the Company at (800) 977-4698 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

PART VII
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any Coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when confined as an Inpatient; and 2) general nursing care provided and charged by the Hospital.

2. **Intensive Care:** If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses:** 1) when confined as an Inpatient; or 2) as a precondition for being confined as an Inpatient. Benefits will be paid for services and supplies 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.

4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames. No deductible is applied for benefits provided for the newborn baby. Newborn care does not include any services provided after the mother has been discharged from the Hospital.

5. **Physiotherapy (Inpatient):** See Schedule of Benefits.

6. **Surgery:** Physician's fees for Inpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. The first procedure will be paid in accordance with our standard reimbursement policy.

7. **Assistant Surgeon Fees:** in connection with Inpatient surgery, if provided in the Schedule of Benefits.

8. **Anesthetist Services:** professional services administered in connection with Inpatient surgery.

9. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while an Inpatient; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital, is not covered under this benefit.

10. **Physician's Visits (Inpatient):** non-surgical services when confined as an Inpatient. Benefits are limited to one visit per day. Covered Medical Expenses will be paid under the Inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.

11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.

12. **Surgery (Outpatient):** Physician's fees for outpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. The first procedure will be paid in accordance with our standard reimbursement policy.

13. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.

14. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

15. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

16. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Covered Medical Expenses will be paid under the outpatient benefit or under the Inpatient benefit for Physician's Visits, but not both on the same day. Physician's Visits for preventive care are provided as specified under Preventive Care Services.

17. **Physiotherapy (Outpatient):** benefits are limited to one visit per day. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.

18. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the attending Physician's charges, the facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.

19. **Diagnostic X-ray Services (Outpatient):** Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.

20. **Radiation Therapy (Outpatient):** See Schedule of Benefits.

21. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

22. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures. The following therapies will be paid under the Tests and Procedures (Outpatient) benefit: inhalation therapy; infusion therapy; pulmonary therapy; and respiratory therapy. Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

23. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

24. **Chemotherapy (Outpatient):** See Schedule of Benefits.

25. **Prescription Drugs (Outpatient):** See Schedule of Benefits.

26. **Ambulance Services:** See Schedule of Benefits.

27. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. Durable medical equipment includes prosthetic devices as provided for in the Benefits for Prosthetic Devices. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

28. **Consultant Physician Fees:** when requested and approved by the attending Physician.

29. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

30. **Mental Illness Treatment:** the benefits are specified in the Schedule of Benefits. See Benefits for Mental Illness and Substance Use Disorder.

31. **Substance Use Disorder Treatment:** the benefits are specified in the Schedule of Benefits. See Benefits for Mental Illness and Substance Use Disorder.

32. **Maternity:** Same as any other Sickness. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.

33. **Complications of Pregnancy:** Same as any other Sickness.

34. **Preventive Care Services:** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

35. **Reconstructive Breast Surgery Following Mastectomy:** same as any other Sickness and in connection with a covered mastectomy. See Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery.

36. **Diabetes Services:** same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes Treatment.

37. **Repatriation:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.

38. **Medical Evacuation:** 1) when Hospital Confined for at least three - five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.

39. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

PART VIII
MANDATED BENEFITS

BENEFITS FOR ANNUAL GYNECOLOGICAL EXAMINATION AND PAP TEST

Benefits will be paid the same as any other Sickness for an annual gynecological examination including routine pelvic and clinical breast examinations. Benefits will also be paid the same as any other Sickness for screening Pap tests recommended by a Physician.

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

BENEFITS FOR BREAST CANCER TREATMENT AND RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid the same as any other Sickness for breast cancer treatment and post-mastectomy reconstruction.

Coverage for the treatment of breast cancer shall be provided for a period of time determined by the attending Physician, in consultation with the patient, to be Medically Necessary following a mastectomy, a lumpectomy or a lymph node dissection.

Post mastectomy reconstruction includes the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the Insured elects reconstruction and in the manner chosen by the Insured and the Physician.

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

BENEFITS FOR MAMMOGRAM

Benefits will be paid the same as any other Sickness for screening mammograms performed by Physicians that meet the standards established by the Department of Human Services rules relating to radiation protection. A screening mammogram also includes an additional radiological procedure recommended by a Physician when the results of an initial radiologic procedure are not definitive. Benefits will be provided for screening mammograms performed at least once a year for Insureds 40 years of age and over.

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for Services For The Early Detection of Prostate Cancer. Services for the early detection of prostate cancer means the following procedures provided to a man for the purpose of early detection of prostate cancer: (a) a digital rectal examination; and (b) a prostate-specific antigen test. Benefits shall be provided for services for the early detection of prostate cancer, if recommended by a Physician, at least once a year for Insureds 50 years of age or older until an Insured reaches the age of 72.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for Colorectal Cancer Screening for asymptomatic Insured's who are: (a) 50 years of age; or (b) less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the National Cancer Society.

"Colorectal Cancer Screening" means a colorectal cancer examination and laboratory test recommended by a Physician in accordance with the most recently published colorectal cancer screening guidelines of the National Cancer Society.

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

BENEFITS FOR CHIROPRACTIC SERVICES

Benefits will be paid the same as any other Sickness for services performed by a chiropractor to the extent that services are within the lawful scope of practice of a chiropractor licensed to practice in Maine. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

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

BENEFITS FOR DIABETES TREATMENT

Benefits will be paid the same as any other Sickness for the Medically Necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if: (1) the Insured's treating Physician or a Physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and (2) the diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

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

BENEFITS FOR MODIFIED LOW-PROTEIN FOOD PRODUCT

Benefits will be paid the same as any other Sickness for metabolic formula and Special Modified Low-Protein Food Products that have been prescribed by a licensed Physician for a person with an Inborn Error of Metabolism. Benefits shall be provided for metabolic formula and not to exceed $3,000.00 per policy year for Special Modified Low-Protein Food Products.

Inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. Special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

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

BENEFITS FOR MEDICALLY NECESSARY INFANT FORMULA

Benefits will be paid the same as any other Sickness for amino acid-based elemental infant formula for Dependent children 2 years of age and under when a Physician has diagnosed and through medical evaluation has documented one of the following conditions: (a) symptomatic allergic colitis or proctitis; (b) laboratory or biopsy-proven allergic or eosinophilic gastroenteritis; (c) a history of anaphylaxis; (d) gastroesophageal reflux disease that is nonresponsive to standard medical therapies; (e) severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; (f) cystic fibrosis; or (g) malabsorption of cow milk-based or soy milk-based infant formula.

The Physician shall submit documentation that the amino acid-based elemental infant formula is a Medical Necessity and that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A Physician may be required to confirm and document ongoing Medical Necessity at least annually.

Benefits will be paid without regard to the method of delivery of the formula.

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

BENEFITS FOR CONTRACEPTIVES

Benefits will be paid the same as any other Prescription Drugs for all prescription contraceptives approved by the federal Food and Drug Administration. In addition, benefits will be paid the same as any other Sickness for outpatient contraceptive services provided by a Physician.

"Outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. The benefit may not be construed to apply to Prescription Drugs or devices that are designed to terminate a pregnancy.

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

BENEFITS FOR MENTAL ILLNESS AND SUBSTANCE USE DISORDER

Benefits will be paid the same as any other Sickness for Mental Illness, and Substance Use Disorder.

Benefits for an Insured suffering from Mental Illness include the following: Inpatient care; Day treatment services; Outpatient services; Home health care services.

Mental illness shall include the following categories as defined in the Diagnostic and Statistical Manual, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;
(2) Dissociative disorders;
(3) Mood disorders;
(4) Anxiety disorders;
(5) Personality disorders;
(6) Paraphilias
(7) Attention deficit and disruptive behavior disorders;
(8) Pervasive development disorders;
(9) Tic disorders;
(10) Eating disorders, including bulimia and anorexia; and
(11) Substance use disorders.

Benefits for Substance Use Disorder will include residential treatment at a hospital or free-standing residential treatment center which is licensed, certified or approved by the State; and outpatient care rendered by state licensed, certified or approved providers.

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

BENEFITS FOR CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for Routine Patient Costs in connection with participation in an Approved Clinical Trial.

Qualified Insured: An Insured is eligible for coverage for participation in an Approved Clinical Trial if the Insured meets the following conditions:

A. The Insured has a life-threatening Sickness for which no standard treatment is effective;
B. The Insured is eligible to participate according to the clinical trial protocol with respect to treatment of such Sickness;
C. The Insured's participation in the trial offers meaningful potential for significant clinical benefit to the Insured; and
D. The Insured's referring Physician has concluded that the Insured's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.

"Approved clinical trial," means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

"Routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

In the case of Covered Medical Expenses, the Company shall pay Participating Providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by Participating Providers.

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

BENEFITS FOR HOSPICE CARE SERVICES

Benefits will be paid the same as any Sickness for Hospice Care Services to an Insured who is Terminally Ill.

Hospice Care Services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of Hospice Care Services. Coverage for Hospice Care Services will be provided whether the services are provided in a home setting or an inpatient setting.

"Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to an Insured who is terminally ill and that Insured's family. Hospice care services includes, but is not limited to, Physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services.

"Terminally ill" means an Insured that has a medical prognosis that the life expectancy is 12 months or less if the Sickness runs its normal course.

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

BENEFITS FOR GENERAL ANESTHESIA FOR DENTISTRY

Benefits will be paid the same as any Sickness for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the clinical status or underlying medical condition of an Insured requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital.

This section applies only to general anesthesia and associated facility charges for only the following Insureds:

A. Insureds, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;
B. Insureds demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and
D. Insureds who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

This does not include benefits for any charges for the dental procedure itself, other than specifically provided for in the Schedule of Benefits, including, but not limited to, the professional fee of the dentist.

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

BENEFITS FOR PROSTHETIC DEVICES

Benefits will be paid the same as any Sickness for Prosthetic Devices determined by the Insured's Physician to be the most appropriate model that adequately meets the medical needs of the Insured. Benefits will include repair and replacement of a Prosthetic Device if the Insured's Physician determines such repair or replacement appropriate.

Prosthetic Device means an artificial device to replace, in whole or in part, an arm or a leg.

No coverage will be provided for a Prosthetic Device that is designed exclusively for athletic purposes.

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

BENEFITS FOR TELEMEDICINE SERVICES

Benefits will be paid the same as any other sickness for health care services provided by means of Telemedicine if such health care services would be Covered Medical Expenses under this policy and if rendered on an in-person consultation basis.

"Telemedicine" means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine or email.

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

BENEFITS FOR OFF-LABEL DRUG USE

Benefits will be paid the same as any other Prescription Drug, including medically necessary services associated with the administration of such drugs, for the Off-Label Use of Prescription Drugs for the treatment of cancer or HIV/AIDS.

Benefits will not be denied for Prescription Drugs under this provision based on Medical Necessity, unless such denial is unrelated to the legal status of the drug's use. Benefits will not be paid for Prescription Drugs under this provision where the use is contraindicated by the federal Food and Drug Administration.

"Off-Label Use" means the use of a federal Food and Drug Administration approved drug for indications other than those stated in labeling that it has approved. The drug need not have been approved for the treatment of cancer or of HIV/AIDS if the use of such drug is supported by one or more citations in (a) the United States Pharmacopeia Drug Information or its successors; (b) the American Hospital Formulary Service Drug Information or its successors; or (c) Peer-reviewed Medical Literature.

"Peer-reviewed Medical Literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals. These articles must present evidence that supports the Off-Label Use as generally safe and effective.

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

BENEFITS FOR HEARING AIDS

Benefits will be provided for the purchase of a Hearing Aid for each hearing-impaired ear for an Insured Person who is 5 years of age or under. The hearing loss must be documented by a Physician or audiologist. The Hearing Aid must be purchased from an audiologist or appropriately licensed hearing aid dealer. Benefits are limited to $1,400 per Hearing Aid for each hearing-impaired ear every 36 months.

"Hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

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

PART IX
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. Learning disabilities, except as specifically provided in the policy;

2. Congenital conditions, except as specifically provided for Newborn Infants;

3. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn children;

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

5. Elective Surgery or Elective Treatment;

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 covered Injury or disease process;

7. Hearing examinations; hearing aids, except as specifically provided under the Benefits for Hearing Aids or cochlear implants; other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

8. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;

9. Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;

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

11. Injury sustained while (a) participating in any intercollegiate, club or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

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

13. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;

14. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes Treatment;
    b) Biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs, except as specifically provided in the Benefits for Off-Label Drug Use;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

15. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;

16. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;

17. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;

18. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

19. Temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof;

20. Skydiving, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

21. Supplies, except as specifically provided in the policy;

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

23. 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).

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

COORDINATION OF BENEFITS PROVISION

Definitions

(1) **Allowable Expenses:** Any health care expense, including coinsurance, or copayments and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.

(a) The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.
(b) For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
(c) For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
(d) If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

The amount of any benefit reduction by the Primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admission, and preferred provider arrangements.

(2) **Plan:** A form of coverage with which coordination is allowed.

Plan includes all of the following:
(a) Group insurance contracts and subscriber contracts.
(b) Uninsured arrangements of group or group-type coverage.
(c) Group coverage through closed panel plans.
(d) Group-type contracts, including blanket contracts.
(e) The medical care components of long-term care contracts, such as skilled nursing care.
(f) The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.
(g) Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

Plan does not include any of the following:

(a) Hospital indemnity coverage benefits or other fixed indemnity coverage.
(b) Accident only coverage.
(c) Limited benefit health coverage as defined by state law.
(d) Specified disease or specified accident coverage.
(e) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
(f) Benefits provided in long term care insurance poli.ies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
(g) Medicare supplement policies.
(h) State Plans under Medicaid.
(i) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
(j) An Individual Health Insurance Contract.

(3) **Primary Plan:** A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a primary plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.

(4) **Secondary Plan:** A Plan that is not the Primary Plan.

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

Rules for Coordination of Benefits - When an Insured Person is covered by two or more Plans, the rules for determining the order of benefit payments are outlined below.

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan.

A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary. This does not apply to coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out of network benefits.

If the Primary Plan is a closed panel plan and the Secondary Plan is not a closed panel plan, the Secondary Plan shall pay or provide benefits as if it were the Primary Plan when an Insured Person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Order of Benefit Determination - Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the plan covering the person as a dependent; and (ii) primary to the plan covering the person as other than a dependent, then the order of benefit is reversed. The plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(2) Dependent Child/Parents Married or Living Together. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:

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

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

(3) Dependent Child/Parents Divorced, Separated or Not Living Together. If two or more Plans cover a person as a Dependent child of parents who are divorced or separated or are not living together, whether or not they have ever been married, benefits for the child are determined in this order:

If the specific terms of a court decree state that one of the parents is responsible for the health care services or expenses of the child and that Plan has actual knowledge of those terms, that Plan is Primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's Plan is Primary. This item shall not apply with respect to any Plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

If a court decree states that both parents are responsible for the child's health care expenses or coverage, the order of benefit shall be determined in accordance with part (2).

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the order of benefits shall be determined in accordance with the rules in part (2).

If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:

(a) First, the Plan of the parent with custody of the child.
(b) Then Plan of the spouse of the parent with the custody of the child.
(c) The Plan of the parent not having custody of the child.
(d) Finally, the Plan of the spouse of the parent not having custody of the child.

(4) Dependent Child/Non-Parental Coverage. If a Dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as if those individuals were parents of the child.

(5) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(6) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

(a) First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
(b) Second, the benefits under the COBRA or continuation coverage.
(c) If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

If none of the provisions stated above determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on Benefits - When Our Plan is secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to the Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

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

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

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

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

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.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

UnitedHealthcare Network Pharmacy Prescription Drug Benefits

Benefits are available for Prescription Drug Products at a Network Pharmacy as specified in the policy Schedule of Benefits subject to all terms of the policy and the provisions, definitions and exclusions specified in this endorsement.

Copayment and/or Coinsurance Amount

For Prescription Drug Products at a retail Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance; or
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Schedule of Benefits. For a single Copayment and/or Coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.uhcsr.com or by calling *Customer Service* 1-877-417-7345.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change, and therefore the Copayment and/or Coinsurance may change and an Ancillary Charge may apply. The Insured will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug is assigned.

Notification Requirements

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Insured's Physician, Insured's pharmacist or the Insured is required to notify the Company or our designee. The reason for notifying the Company is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Medical Expense.
- It is not an Experimental or Investigational or Unproven Service.

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.uhscr.com or by calling *Customer Service* at 1-877-417-7345.

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured can ask the Company to consider reimbursement after the Insured receives the Prescription Drug Product. The Insured will be required to pay for the Prescription Drug Product at the pharmacy.

When the Insured submits a claim on this basis, the Insured may pay more because they did not notify the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance, and any Deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Company reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Medical Expense or it is an Experimental or Investigational or Unproven Service.

Limitation on Selection of Pharmacies

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person's selection of Network Pharmacies may be limited. If this happens, the Company may require the Insured to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the designated single Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will select a single Network Pharmacy for the Insured.

Coverage Policies and Guidelines

The Company's Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on its behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

The Company may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to the Insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. Please access www.uhcsr.com through the Internet or call *Customer Service* at 1-877-417-7345 for the most up-to-date tier status.

Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company does not pass these rebates on to the Insured Person, nor are they applied to the Insured's Deductible or taken into account in determining the Insured's Copayments and/or Coinsurance.

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Endorsement. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

Definitions

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

Chemically Equivalent means when Prescription Drug Products contain the same active ingredient.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

1) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
2) Subject to review and approval by any institutional review board for the proposed use.
3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If the Insured has a life-threatening Injury or Sickness (one which is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

1) Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
2) Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Unproven Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network 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 Cost means the rate the Company has agreed to pay the Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

Prescription Drug List Management Committee means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

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

Usual and Customary Fee means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Fee includes a dispensing fee and any applicable sales tax.

Additional Exclusions

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

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-2.

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.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

RESOLUTION OF GRIEVANCES

Internal Inquiry Process

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

If the Insured has a complaint about a claim denial, the Insured may call our Member Services telephone number 1-800-767-0700 for further explanation to informally resolve the complaint or contact the consumer assistance toll-free number maintained by the Office of Patient Protection at 1-800-436-7757. If the Insured is not satisfied with our explanation of why the claim was denied, the Insured, the Insured's authorized representative, or the Insured's provider may request an internal review of the claim denial.

The following is the Company's internal inquiry process:

1) The Insured must request in writing a benefit review within 60 days after receipt of the claim notice. This will be an informal reconsideration review process of the claim by a Claims Supervisor. This process is not used for clinical reviews. The Insured may not attend this review.

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

3) The Company will provide written notice to an Insured whose inquiry has not been explained or resolved to the Insured's satisfaction within three business days of the inquiry of the right to have the inquiry processed as an internal grievance under 105 CMR 128.300 through 128.313 at his/her option, including reduction of an oral inquiry to writing by the Company, written acknowledgment and written resolution of the grievance as set forth in 105 CMR 128.300 through 128.313. The Insured is not required to attend the grievance review.

4) The Company has a system for maintaining records for a period of two years of each inquiry communicated by an Insured or on his behalf and response thereto. These records shall be subject to inspection by the Commissioner of Insurance and the Office of Patient Protection.

Internal Grievance Review

1) The internal grievance material must be submitted in writing, by electronic means at SGrievances@uhcsr.com or by calling our Member Services telephone number 1-800-767-0700 by the Insured or the authorized representative for consideration by the grievance reviewer. An oral grievance made by the Insured or the authorized representative shall be reduced to writing by the Company and a copy forwarded to the Insured within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company.

2) Within 15 business days after the Company receives the Insured's request for an internal grievance review, the Company must provide the Insured a written acknowledgment of the receipt of the grievance, except where an oral grievance has been reduced to writing by the Company or this time period is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company.

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

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

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

   A) The professional qualifications and licensure of the person or persons reviewing the grievance.
   B) A statement of the reviewer's understanding of the grievance.
   C) The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Company's position. In the case of a grievance that involves an adverse determination, the written resolution shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and shall at a minimum:
      1) identify the specific information upon which the adverse determination was based;
      2) discuss the Insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
      3) specify alternative treatment options covered by the Company, if any;
      4) reference and include applicable clinical practice guidelines and review criteria; and
      5) notify the Insured or the Insured's authorized representative of the procedures for requesting external review.
   D) A reference to the evidence or documentation used as the basis for the decision.
   E) A statement advising the Insured of his or her right to request a reconsideration of the grievance decision and a description of the procedure for submitting a request for a reconsideration of the grievance decision.
   F) With every final adverse determination, the Company shall include a copy of the form prescribed by the Department of Insurance for the request of an external review.

Grievance Decision Reconsideration

1) A grievance decision reconsideration is available to the Insured dissatisfied with the grievance review decision.
2) The Company may offer to the Insured or the Insured's authorized representative, if any, the opportunity for reconsideration of a final adverse determination where relevant medical information:
   a. was received too late to review within the 30 business day time limit; or
   b. was not received but is expected to become available within a reasonable time period following the written resolution.
3) When an Insured or the Insured's authorized representative, if any, chooses to request reconsideration, the Company must agree in writing to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the grievance. The time period for requesting external review shall begin to run on the date of the resolution of the reconsidered grievance.

Expedited Grievance Review

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

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

2) Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the internal grievance process, within 48 hours (or earlier for durable medical equipment at the option of a Physician responsible for treatment or proposed treatment of the covered patient) of receipt of certification by said Physician that, in the Physician's opinion:
    a) the service or use of durable medical equipment at issue in grievance is Medically Necessary;
    b) a denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to the Insured; and
    c) such risk of serious harm is so immediate that the provision of such services of durable medical equipment should not await the outcome of the normal grievance process.
3) Provisions that require that, in the event a Physician exercises the option of automatic reversal earlier than 48 hours for durable medical equipment, the Physician must further certify as to the specific, immediate and severe harm that will result to the Insured absent action within the 48 hour time period.

Expedited Process for Insured with Terminal Illness

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

Failure to Meet Time Limits

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

Coverage or Treatment Pending Resolution of Internal Grievance

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

External Review

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

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

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

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

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

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

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

The Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111
Toll-Free - 1-800-436-7757
FAX – 617-624-5046
www.state.ma.us/dph/opp/

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

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

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

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

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

The Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111
Toll-Free - 1-800-436-7757
FAX – 617-624-5046
www.state.ma.us/dph/opp/

Questions Regarding Appeal Rights
Contact [Customer Service] at [800-767-0700] with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
(800) 272-4232
www.massconsumerassistance.org

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

Claim Procedure

1. Report to the Health Center for treatment or in the case of an emergency, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, Social Security number and name of the College under which the student is insured. A Company claim form is not required for filing a claim.
3. 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.

The Plan is Underwritten by:
HPHC Insurance Company
Administered by
UnitedHealthcare StudentResoruces
Submit all Claims or Inquiries to:
HPHC Insurance Company c/o UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, Texas 75380-9025
800-767-0700
972-233-8200
customerservice@uhcsr.com
claims@uhcsr.com

Sales/Marketing Services:
UnitedHealthcare StudentResources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
1-800-237-0903
E-Mail: info@uhcsr.com

For questions concerning coverage or claims:
Cross Insurance
217 Main Street
Lewiston, ME 04240
1-800-537-6444
www.crossagency.com

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the College 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 # 2012-1295-1 v1