Harvard Pilgrim Health Care

UnitedHealthcare®

Read Your Certificate Carefully

2015–2016 Student Injury and Sickness Insurance Plan

NON-RENEWABLE ONE YEAR TERM INSURANCE

Designed Especially for the Students of

המכללה העברית
HEBREW COLLEGE

This plan is made available through participation in the Midwestern Higher Education Compact (MHEC)

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

THIS PLAN DOES NOT INCLUDE ANY EXCLUSIONS OR LIMITATIONS FOR PRE-EXISITING CONDITIONS.

This health plan meets the Minimum Creditable Coverage standards that are effective January 1, 2014 as part of the Massachusetts Health Care Reform Law. This plan will satisfy the requirement that the Insured Person must have health insurance meeting these standards.

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

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

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

So that you can receive the highest level of benefits from the Plan, you should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the Plan's web site at www.uhcsr.com/hebrewcollege. The web site will allow you to easily search for providers by specialty and location. You may also call the Customer Service Department at 1-800-977-4698, toll free, for assistance in finding a Preferred Provider. The Customer Service Department can also send you a copy of the Plan's Provider Directory. If no Preferred Provider has the expertise needed to meet your medical needs, we will assist you in finding an appropriate Out-of-Network Provider.

Please feel free to call the Customer Service Department with any questions you may have about the Plan. The telephone number is 1-800-977-4698. You can also write us at:

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

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-977-4698 or visiting us at our administrator's website at www.uhcsr.com/hebrewcollege.

Eligibility

All eligible registered students taking credit hours are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished.

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

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse and dependent children under 26 years of age.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., September 1, 2015. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 31, 2016. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Rates	Annual 9/1/15 – 8/31/16	Fall 9/1/15 – 1/31/16	Spring/Summer 2/1/16 – 8/31/16	Summer 7/1/16 – 8/31/16
Student	$2,007.00	$839.00	$1,168.00	$339.00
Spouse	$2,007.00	$839.00	$1,168.00	$339.00
One Child	$2,007.00	$839.00	$1,168.00	$339.00
Two or more Children	$4,014.00	$1,678.00	$2,336.00	$678.00
Spouse and 2 or more Children	$6,021.00	$2,517.00	$3,504.00	$1,017.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which are paid to certain non-insurer vendors or consultants by, or at the direction, of your school.

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

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. There is a Grace Period of 14 days to receive premium after the first premium. To avoid a lapse in coverage, your premium must be received within 14 days after the premium expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

Refunds of premiums are allowed only under the following circumstances:

1. The Insured's entry into the armed forces. A pro-rata premium will be refunded upon request.
2. The Named Insured paid to enroll in the policy for an entire Policy Year but is not a student at the beginning of a school term during the Policy Year. A pro-rata premium by term will be refunded upon request for the terms during which the Named Insured is not an eligible student. This refund is not available if the student disenrolls from school during the term.
3. The Named Insured paid to enroll in the policy for an entire Policy Year but becomes eligible for a subsidized Health Benefit Plan through the Connector or becomes eligible for MassHealth and who uses enrollment in such coverage to waive coverage under this policy. The Named Insured must become eligible for the other coverage prior to the beginning of the term for which the refund is requested. A pro-rata premium by term will be refunded upon request for the terms during which the Named Insured waives coverage under this policy.

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

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

Continuation of Coverage upon Divorce or Separation:
A Dependent spouse may elect to continue coverage under this policy in the event that the spouse's coverage terminates due to divorce or legal separation from the Named Insured, unless the judgment of divorce or separation provides otherwise. Coverage will, in no event, continue beyond the earliest of one of the following:

1) The remarriage of either the Named Insured or the former Dependent spouse. However, upon remarriage of the Named Insured, if provided in the judgment of divorce, the former Dependent spouse may elect to continue coverage at additional premium rates, as determined by the Company.
2) The date that the Named Insured's coverage terminates.
3) The period of time set forth in the judgment of divorce or separation.
4) The last day for which the Company has received the required premium.
5) The date the policy terminates.

Involuntary Disenrollment Rate

The involuntary disenrollment rate for Insureds in Massachusetts for HPHC Insurance Company for 2014 was 0%.

Physician Information

Physician profiling information, so-called, may be available from the Board of Registration in Medicine for Physicians licensed to practice in Massachusetts.

Consumer Information

An Insured Person may contact the Company to obtain information regarding benefits, Copayments, Deductibles, Coinsurance, or other out-of-pocket expenses related to a proposed admission, procedure, or service that is covered under the Policy. An Insured may also request an estimated amount the Insured would be responsible for paying for an admission, procedure or service based on the information available to the Company at the time the request is made. An Insured may also request an estimated or maximum allowed amount or charge for a proposed admission, procedure or service.

The information provided will be an estimate. Actual amounts may vary based on unforeseen services and expenses that arise out of any proposed admission, procedure, or service.

To obtain information, the Insured may contact the Company at:

Real Time Information available Toll-Free Telephone 800-977-4698 Monday through Friday – 7:00am to 7:00 pm Central Time
Online at: www.uhcsr.com/hebrewcollege
Real Time Information available Monday through Friday – 7:00am to 7:00 pm Central Time

Complaint Resolution

Insured Persons, Preferred Providers, Out-of-Network Providers or their representatives with questions or complaints may call the Customer Service Department at 1-800-977-4698. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

Extension of Benefits after Termination

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

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

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

Pre-Admission Notification

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

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

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

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

Benefits Payable

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

Preferred Provider Information

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

"Preferred Providers" are the Physicians, Hospitals and other health care providers who participate in 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 the geographic service area approved by the Massachusetts Division of Insurance.

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

Inpatient Expenses

PREFERRED PROVIDERS – Eligible Inpatient expenses at a Preferred 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 facilities. Call 1-800-977-4698 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.

Schedule of Medical Expense Benefits

Metallic Level - Gold
Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible Preferred Providers	**$500 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network	**$1,000 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Providers	**75% except as noted below**
Coinsurance Out-of-Network	**55% except as noted below**
Out-of-Pocket Maximum Preferred Providers	**$5,000 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Providers	**$10,000 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$10,000 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$20,000 (For all Insureds in a Family, Per Policy Year)**

The Preferred Provider for this plan is HPHC Insurance Company Network.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred for Emergency Services when 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.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network per service Deductibles.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, 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.

Please refer to the Medical Expense Benefits – Injury and Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider	Out-of-Network
Room & Board Expense:	Preferred Allowance	Usual and Customary Charges
Intensive Care:	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses:	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care: See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care.	Paid as any other Sickness	Paid as any other Sickness

Inpatient	Preferred Provider	Out-of-Network
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.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees:	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist Services:	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: Payable within 7 working days prior to admission.	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
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.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous: Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees:	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist Services:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	100% of Preferred Allowance $25 Copay per visit	Usual and Customary Charges
Physiotherapy: Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Cardiac Rehabilitation, Benefits for Treatment of Autism Spectrum Disorder, and Benefits for Treatment of Speech, Hearing and Language Disorders.	Preferred Allowance $50 Copay per visit	Usual and Customary Charges
Medical Emergency Expenses: Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. The Copay/per visit Deductible will be waived if admitted to the Hospital.	Preferred Allowance $150 Copay per visit	75% of Usual and Customary Charges $150 Deductible per visit
Diagnostic X-ray Services:	Preferred Allowance	Usual and Customary Charges
Radiation Therapy:	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures:	Preferred Allowance	Usual and Customary Charges
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
Chemotherapy:	Preferred Allowance	Usual and Customary Charges
Prescription Drugs and medicines lawfully obtainable only upon written prescription of a Physician:	UnitedHealthcare Pharmacy (UHCP) $10 Copay per prescription for Tier 1 $40 Copay per prescription for Tier 2 $60 Copay per prescription for Tier 3 up to a 31-day supply per prescription *(Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay, up to a 90 day supply.)*	$10 Deductible per prescription for generic drugs $40 Deductible per prescription for brand name drugs up to a 31-day supply per prescription

Other	Preferred Provider	Out-of-Network
Ambulance Services:	Preferred Allowance	75% of Usual and Customary Charges
Durable Medical Equipment: See also Benefits for Prosthetic Devices and Repair.	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees:	100% of Preferred Allowance $50 Copay per visit	Usual and Customary Charges
Dental Treatment: $5,000 maximum per Policy Year. Benefits paid on Injury to Sound, Natural Teeth only or as specifically provided in the policy.	Preferred Allowance	75% of Usual and Customary Charges
Mental Illness Treatment: See Benefits for Treatment of Mental Disorders.	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment: See Benefits for Treatment of Mental Disorders.	Paid as any other Sickness	Paid as any other Sickness
Maternity: See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care.	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion:	No Benefits	No Benefits
Complications of Pregnancy: See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care.	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services: No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. See also Benefits for Cytologic Screening and Mammographic Examinations, Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care, Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services, and Benefits for Dependent Children Preventive Care.	100% of Preferred Allowance	No Benefits
Reconstructive Breast Surgery Following Mastectomy: See Benefits for Initial Prosthetic Devices and Reconstructive Surgery Incident to Mastectomy.	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services: See Benefits for Treatment of Diabetes.	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider	Out-of-Network
Home Health Care: See Benefits for Home Health Care.	Preferred Allowance	Usual and Customary Charges
Hospice Care: See Benefits for Hospice Care.	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility:	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility:	Preferred Allowance	Usual and Customary Charges
Urgent Care Center:	Preferred Allowance	Usual and Customary Charges
Hospital Outpatient Facility or Clinic:	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials: See also Benefits for Qualified Clinical Trials for Treatment of Cancer.	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services:	Paid as any other Sickness	Paid as any other Sickness
Ostomy Supplies:	Preferred Allowance	Usual and Customary Charges
Weight Loss Programs:	Paid as any other Sickness	Paid as any other Sickness

UnitedHealthcare Pharmacy Benefits

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

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com/hebrewcollege or call 1-855-828-7716 for the most up-to-date tier status.

$10 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

$40 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

$60 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

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

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

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

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

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com/hebrewcollege and log in to your online account or call 1-855-828-7716.

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

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. 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.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
7. 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.
8. 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.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

Definitions:

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.

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

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. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
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.

Exceptions:

1. Clinical trials for which benefits are specifically provided for in the policy.
2. If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

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, consider an otherwise Unproven Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

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.

New Prescription Drug Product means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

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/hebrewcollege or call *Customer Service* at 1-855-828-7716.

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

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

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

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.

Medical Expense Benefits – Injury and Sickness

This section describes Covered Medical Expenses for which benefits are available in the Schedule of Benefits.

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 amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance, Copayment or per service Deductible amounts set forth in the Schedule of Benefits or any benefit provision hereto. 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:

Inpatient

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

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

3. **Hospital Miscellaneous Expenses.**
When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

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.
- Supplies.

4. **Routine Newborn Care.**
See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care.

5. **Surgery (Inpatient).**
Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**
Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**
Registered Nurse's services which are all of the following:
- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.

9. **Physician's Visits (Inpatient).**
Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

10. **Pre-admission Testing.**
Benefits are limited to routine tests such as:
- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the policy, major diagnostic procedures such as those listed below will be paid under the "Hospital Miscellaneous" benefit:
- CT scans.
- NMR's.
- Blood chemistries.

Outpatient

11. **Surgery (Outpatient).**
Physician's fees for outpatient surgery.

12. **Day Surgery Miscellaneous (Outpatient).**
Facility charge and the charge for services and supplies 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.

13. **Assistant Surgeon Fees (Outpatient).**
Assistant Surgeon fees in connection with outpatient surgery.

14. **Anesthetist Services (Outpatient).**
Professional services administered in connection with outpatient surgery.

15. **Physician's Visits (Outpatient).**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery or Physiotherapy.

Physician's Visits for preventive care are provided as specified under Preventive Care Services.

16. **Physiotherapy (Outpatient).**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy.

See also Benefits for Cardiac Rehabilitation, Benefits for Treatment of Autism Spectrum Disorders, and Benefits for Treatment of Speech, Hearing and Language Disorders.

17. **Medical Emergency Expenses (Outpatient).**
Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies and:
- The attending Physician's charges.
- X-rays.
- Laboratory procedures.
- Tests and procedures.
- Injections.

18. **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.

19. **Radiation Therapy (Outpatient).**
See Schedule of Benefits.

20. **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.

21. **Tests and Procedures (Outpatient).**
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
- Physician's Visits.
- Physiotherapy.
- X-Rays.
- Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.

Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. **Injections (Outpatient)**.
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy (Outpatient).**
See Schedule of Benefits.

24. **Prescription Drugs (Outpatient).**
See Schedule of Benefits.

Other

25. **Ambulance Services.**
Benefits are payable for Medical Emergency only. See Schedule of Benefits.

26. **Durable Medical Equipment.**
Durable medical equipment must be all of the following:

- Provided or prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Primarily and customarily used to serve a medical purpose.
- Can withstand repeated use.
- Generally is not useful to a person in the absence of Injury or Sickness.
- Not consumable or disposable except as needed for the effective use of covered durable medical equipment.

For the purposes of this benefit, the following are considered durable medical equipment:

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Prosthetic devices as provided for in Benefits for Prosthetic Devices and Repair.
- Augmentative communication devices that assist in restoring speech when an Insured is unable to communicate due to an Injury or Sickness.

If more than one piece of equipment or device can meet the Insured's functional needs, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. 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.

27. **Consultant Physician Fees.**
Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Sound, Natural Teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

Benefits will also be paid the same as any other Injury or Sickness for facility charges for a serious medical condition (such as hemophilia or heart disease) that requires an Inpatient Hospital or day surgery facility admission in order for the dental care to be safely performed.

Pediatric dental benefits are provided in the Pediatric Dental Services provision.

29. **Mental Illness Treatment.**
See Benefits for Treatment of Mental Disorders.

30. **Substance Use Disorder Treatment.**
See Benefits for Treatment of Mental Disorders.

31. **Maternity.**
Same as any other Sickness. See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care.

32. **Complications of Pregnancy.**
Same as any other Sickness. See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care.

33. **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:
- 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.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- 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.*
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

See also Benefits for Cytologic Screening and Mammographic Examinations, Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care, and Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services, and Benefits for Dependent Children Preventive Care.

34. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Initial Prosthetic Device and Reconstructive Surgery Incident to Mastectomy.

35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Treatment of Diabetes.

36. **Home Health Care.**
See Benefits for Home Health Care Services.

37. **Hospice Care.**
See Benefits for Hospice Care.

38. **Inpatient Rehabilitation Facility.**
Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

39. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

40. **Urgent Care Center.**
Benefits are limited to:
- The facility or clinic fee billed by the Urgent Care Center.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

41. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- The facility or clinic fee billed by the Hospital.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

42. **Approved Clinical Trials.**
Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include:

- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

See also Benefits for Qualified Clinical Trials for Treatment of Cancer.

43. **Transplantation Services.**
Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under this policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this policy to be primary.

No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.

Travel expenses are not covered. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

45. **Weight Loss Programs.**
Same as any other Sickness for Hospital-based weight loss programs or non-Hospital based weight loss programs.

44. **Ostomy Supplies.**
Benefits for ostomy supplies are limited to the following supplies:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Maternity Testing

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

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

Initial screening at first visit:

- Pregnancy test: urine human chorionic gonatropin (HCG)
- Asymptomatic bacteriuria: urine culture
- Blood type and Rh antibody
- Rubella
- Pregnancy-associated plasma protein-A (PAPPA) **(first trimester only)**
- Free beta human chorionic gonadotrophin (hCG) **(first trimester only)**
- Hepatitis B: HBsAg
- Pap smear
- Gonorrhea: Gc culture
- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test
- Cystic fibrosis screening

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

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

Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS), non-invasive fetal aneuploidy DNA testing

Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered, except folic acid supplements with a written prescription. For additional information regarding Maternity Testing, please call the Company at 1-800-977-4698.

Mandated Benefits

Benefits for Cardiac Rehabilitation

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

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

Benefits for Cytologic Screening and Mammographic Examinations

Benefits will be paid the same as any other Sickness for:

1. An annual cytologic screening for women eighteen (18) years of age or older.
2. A baseline mammogram for women between the ages thirty-five (35) and forty (40).
3. An annual mammogram for women forty (40) years of age and older.

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

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

Benefits for Infertility Treatment

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

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

Benefits are not provided for the following Experimental Infertility Procedures:

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

"**Infertility**" means:

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

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

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

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

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

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

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

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

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

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

Benefits for Enteral Formula

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

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

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

Benefits for Bone Marrow Transplants for Treatment of Breast Cancer

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

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

Benefits for Human Leukocyte Antigen or Histocompatibility Locus Antigen Testing

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

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

Benefits for Initial Prosthetic Device and Reconstructive Surgery Incident to Mastectomy

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

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

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

Benefits for Scalp Hair Prostheses

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

Benefits shall include coverage when hair loss is due to chemotherapy, radiation therapy, infections, burns, traumatic Injury, congenital baldness, and Sicknesses resulting in alopecia areata or alopecia totalis (capitus).

Benefits do not include any scalp hair prostheses worn for male pattern baldness, female pattern baldness, natural aging, or premature aging.

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

Benefits for Hospice Care

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

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

Benefits for Home Health Care Services

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

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

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

Benefits for Treatment of Diabetes

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

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

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

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

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

Benefits for Treatment of Speech, Hearing, and Language Disorders

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

Benefits include coverage for the full cost of hearing aids for Insured Persons who are 21 years of age or younger. Benefits are available for a hearing aid that is determined to be Medically Necessary by the Insured's Physician. Benefits are limited to one hearing aid per hearing impaired ear, up to $2,000 for each hearing aid every 36 months. Benefits shall include the initial hearing aid evaluation, fitting, adjustments, and supplies, including ear molds.

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

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

Benefits will be paid the same as any other Prescription Drug for any drug prescribed to treat an Insured Person for cancer or HIV/AIDS if the drug is recognized treatment for that indication in one of the Standard Reference Compendia, in Medical Literature, or in the Association of Community Cancer Centers' Compendia-Based Drug Bulletin.

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

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

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

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

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

Benefits for Treatment of Mental Disorders

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

1. Schizophrenia.
2. Schizoaffective disorder.
3. Major depressive disorder.
4. Bipolar disorder.
5. Paranoia and other psychotic disorders.
6. Obsessive-compulsive disorder.
7. Panic disorder.
8. Delirium and dementia.
9. Affective disorders.
10. Eating disorders.
11. Post traumatic stress disorder.
12. Substance abuse disorders.
13. Autism.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Benefits for Treatment of Autism Spectrum Disorders

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

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

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

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

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

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

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

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

Benefits for Treatment of Cleft Lip and Cleft Palate

Benefits will be paid the same as any other Sickness for the cost of treating cleft lip and cleft palate for an Insured Person under the age of 18.

Benefits shall include:

1. Medical, dental, oral, and facial surgery.
2. Surgical management and follow-up care by oral and plastic surgeons.
3. Orthodontic treatment and management.
4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment.
5. Prosthetic management therapy, speech therapy, audiology, and nutrition services, if such services are:
   a. Prescribed by the treating Physician.
   b. Certified by the treating Physician to be Medically Necessary.
   c. Consequent to the treatment of cleft lip or cleft palate.

Benefits provided under this section shall not include dental or orthodontic treatment not related to the management of cleft lip or cleft palate.

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

Benefits for Qualified Clinical Trials for Treatment of Cancer

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

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

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

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

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

Benefits for Prosthetic Devices and Repairs

Benefits will be paid for Medically Necessary Prosthetic Devices and repairs under the same terms and conditions that apply to other durable medical equipment.

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

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

Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services

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

Benefits will be paid the same as any other Sickness for FDA approved hormone replacement therapy and outpatient prescription contraceptive drugs or devices.

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

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

Benefits for Hypodermic Syringes or Needles

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

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

Benefits for Christian Science Services

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

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

Benefits for Orally Administered Anticancer Medications

Benefits will be provided for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Benefits will be paid on a basis no less favorable than coverage provided for intravenously administered or injected cancer medications.

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

Benefits for Telemedicine

Benefits will be paid the same as any other Sickness for Telemedicine as for services received on a face-to-face basis.

As it pertains to the delivery of health care services, "Telemedicine" means the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does include the use of audio-only telephone, facsimile machine, or electronic mail.

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

Benefits for Newborn or Adopted Children

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

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

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

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

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

Benefits for Dependent Children Preventive Care

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

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

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

Benefits for Dependent Children Early Intervention Services

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

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

Coordination of Benefits Provision

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

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

For Loss Of

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

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

Definitions

ADOPTED OR ADOPTIVE CHILD means:

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

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

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

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

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

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

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

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

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

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at birth.

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.

DEPENDENT means the legal spouse of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

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

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

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

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

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

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

EMERGENCY SERVICES means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

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

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

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

HABILITATIVE SERVICES means outpatient occupational therapy, physical therapy and speech therapy prescribed by the Insured Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

Habilitative services do not include services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Insured Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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

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

INJURY means bodily injury which is all of the following:

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

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

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

INPATIENT REHABILITATION FACILITY means a long term acute inpatient rehabilitation center, a Hospital (or special unit of a Hospital designated as an inpatient rehabilitation facility) that provides rehabilitation health services on an Inpatient basis as authorized by law.

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

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

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

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

1. Placing the health of the Insured Person or another person in serious jeopardy.
2. Serious impairment to body function, or serious dysfunction of any body organ or part.
3. With respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

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

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

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

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

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

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

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

PHYSIOTHERAPY means short-term outpatient rehabilitation therapies (including Habilitative Services) administered by a Physician.

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

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

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

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

SKILLED NURSING FACILITY means a Hospital or nursing facility that is licensed and operated as required by law.

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

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

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

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

Exclusions and Limitations

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

1. Acupuncture.
2. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
3. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
4. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As described under Dental Treatment in the policy.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
5. Elective Surgery or Elective Treatment.
6. Elective abortion.
7. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
8. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

   This exclusion does not apply to preventive foot care for Insured Persons with systemic circulatory diseases such as diabetes.
9. Health spa or similar facilities. Strengthening programs.
10. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of an infection or Injury.
    - Benefits specifically provided in Benefits for Treatment of Speech, Hearing and Language Disorders.
11. Hirsutism.
12. Hypnosis.
13. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
14. Injury caused by, contributed to, or resulting from the use of:
    - Intoxicants.
    - Hallucinogenics.
    - Illegal drugs.
    - Any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician.
15. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
16. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.

17. Injury sustained while:
    - Participating in any intercollegiate, or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
18. Investigational services.
19. Learning disabilities testing, including diagnostic testing of learning disabilities.
20. Lipectomy.
21. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
22. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
    - Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
    - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Sexual enhancement drugs, such as Viagra.
    - Growth hormones.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. Reproductive services for the following, except as specifically provided in Benefits for Infertility:
    - Procreative counseling.
    - Genetic testing.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
24. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.
25. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To contact lenses to treat keratoconus.
26. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care.
27. Preventive care services, except as specifically provided in the Preventive Care Services benefit or except as specifically provided in the policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.
28. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
29. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
30. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
31. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
32. Supplies, except as specifically provided in the policy.
33. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
34. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
35. 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).
36. Weight management. Weight reduction. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in Weight Loss Programs.

Medical Emergency Treatment

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

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

UnitedHealthcare Global: Global Emergency Services

If you are a member insured with this insurance plan, you and your insured spouse and minor child(ren) are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

International students, insured spouse and insured minor child(ren): you are eligible to receive UnitedHealthcare Global services worldwide, except in your home country.

Domestic students, insured spouse and insured minor child(ren): you are eligible for UnitedHealthcare Global services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to $5,000.00 payment (when included with Your enrollment in a UnitedHealthcare **Student**Resources health insurance policy)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds

- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

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

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

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

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

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

UnitedHealthcare Global is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. Please refer to the UnitedHealthcare Global information in ***My Account*** at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

NurseLine and Student Assistance

Insureds have immediate access to nurse advice, a health information library, and counseling support 24 hours a day by calling the toll-free number listed on their medical ID card. NurseLine is staffed by both English and Spanish speaking Registered Nurses who can provide health information, support, and guidance on when to seek medical care. The Student Assistance Program coordinates services using a network of resources. Services available include financial and legal advice, as well as mediation. Counseling is also available by Licensed Clinicians who can provide insureds with someone to talk to when everyday issues become overwhelming. Translation services are available in over 170 languages for most services. Insureds also have access to LiveAndWorkWell.com where they can take health risk assessments, use health estimators to calculate things like their target heart rate and BMI, and participate in personalized self-help programs. More information about these services is available by logging into ***My Account*** at www.uhcsr.com/MyAccount.

Online Access to Account Information

Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to ***My Account*** at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "create **My Account** Now" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number.

As part of UnitedHealthcare **Student**Resources' environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account now includes Message Center - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In *Message* Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

Request Paper Documents

At any time, the Insured may request paper copies of any plan documents, including evidences of coverage, any amendments thereto, and any other documents available online.

To request a printed copy, free of charge, the Insured should call us toll-free at 1-800-977-4698.

UHCSR Mobile App

The UHCSR Mobile App is available for download from Google Play or Apple's App Store. Features of the Mobile App include easy access to:

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating Healthcare or Mental Health providers, call the office or facility; view a map.
- Find My Claims – view claims received within the past 60 days for both the primary insured and covered dependents; includes Provider, date of service, status, claim amount and amount paid.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to ***My Account*** as described above and select ***UnitedHealth Allies Plan*** to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

Managed Care Information Provisions

Provider Directories

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

a) by calling 1-800-977-4698; or

b) by logging on to the website at www.uhcsr.com/hebrewcollege for information.

Service Area Directories

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

Continuity of Coverage

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

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

Utilization Review Program

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

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

The Company coordinates certain functions with UnitedHealthcare (UHC) Clinical Services, as described below, and relies on the experience and qualifications of such UHC Medical Claim Review (MCR) Medical Directors when making utilization review determinations.

UHC MCR Medical Directors conduct Medical Necessity reviews for the company. MCR Medical Directors are board-certified physicians who provide clinical review of post service claims. UHC also contracts with several independent External Review Organizations or individual clinicians to perform Medical Necessity reviews for the Company in the State of Massachusetts.

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

1. The Company relies on the experience and training of its Claims Examiners to identify claims for services that may not be Medically Necessary as defined by the plan. Claims for services that are identified by the Claims Examiner as potentially not being Medically Necessary are submitted to the Claims Supervisor for review.
2. If the Claims Supervisor determines that a claim may not be Medically Necessary, then the claim is referred to the Claims Special Investigations Unit for review. Otherwise, the claim is processed according to the terms of the plan.
3. If the Claims Special Investigations Unit Manager determines that a claim may not be Medically Necessary, then the claim is referred to UHC Clinical Services for medical review. Otherwise, the claim is processed according to the terms of the plan.
4. a. If the Medical Reviewer agrees with the determination that services were not Medically Necessary, then the claim is declined. The Medical Reviewer provides the Company with its determination, and the Company is responsible for sending out the declination letter to the Insured and to the provider if applicable.
   b. If the Medical Reviewer disagrees with the determination that services were not Medically Necessary (and therefore is of the opinion that services were Medically Necessary), then the claim is processed according to the terms of the plan.

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

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

Oversight

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

The Utilization Review Program will require substantial involvement of UHC Clinical Services Medical Claims Review Medical Directors. Determinations will be based on the medical reviewers' expert opinion, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice and published clinical criteria from sources recognized in the area of specialty. Those medical standards of practice and published clinical criteria must be used by the Medical Reviewer in making its determinations.

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

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

Clinical Guidelines

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

Quality Assurance

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

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

Payment of Claims Provision

Indemnities payable under the policy for any loss will be paid within forty-five (45) days upon receipt of due written proof of such loss. If payment is not made, the Company will notify the Insured in writing specifying the reasons for the nonpayment or what additional documentation is necessary for payment of the claim. If the Company fails to comply with the terms of this provision, in addition to any benefits payable, interest on such benefits will accrue beginning forty-five (45) days after the Company's receipt of notice of claim at the rate of one and one-half (1 ½) percent per month, not to exceed eighteen (18) percent per year. The interest payments shall not apply to a claim which the Company is investigating because of suspected fraud.

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service for treatment or referral, or when not in school, 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, SR ID number (insured's insurance company ID number) and name of the College under which the student is insured. A Company claim form is not required for filing a claim.

3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

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

Pediatric Dental Services Benefits

Benefits are provided for Covered Dental Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) date the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

Network Benefits apply when the Insured Person chooses to obtain Covered Dental Services from a Network Dental Provider. Insured Persons generally are required to pay less to the Network Dental Provider than they would pay for services from a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will the Insured Person be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, the Insured must obtain all Covered Dental Services directly from or through a Network Dental Provider.

Insured Persons must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. Participation status can be verified by calling the Company and/or the provider. If necessary, the Company can provide assistance in referring the Insured Person to a Network Dental Provider.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 877-816-3596 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured's ID card.

Non-Network Benefits apply when Covered Dental Services are obtained from non-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. As a result, an Insured Person may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. In addition, when Covered Dental Services are obtained from non-Network Dental Providers, the Insured must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

Benefits are eligible for Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, the Insured Person may receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the policy.

A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets the Insured Person know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization
Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If the Insured Person does not obtain a pre-authorization, the Company has a right to deny the claim for failure to comply with this requirement.

If a treatment plan is not submitted, the Insured Person will be responsible for payment of any dental treatment not approved by the Company. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:

A. Necessary.
B. Provided by or under the direction of a Dental Provider.
C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.
D. Not excluded as described in Section 3: Pediatric Dental Services exclusions.

Dental Services Deductible
Benefits for pediatric Dental Services are not subject to the policy Deductible stated in the policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Policy Year is $500 per Insured Person.

Benefits
When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefit Description and Limitations	**Network Benefits** **Benefits are shown as a percentage of Eligible Dental Expenses.**	**Non-Network Benefits** **Benefits are shown as a percentage of Eligible Dental Expenses.**
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 1 set of films every 6 months.	50 %	50 %
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 film every 60 months.	50 %	50 %
Periodic Oral Evaluation (Check up Exam) Limited to 1 every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	50 %	50 %
Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 1 every 6 months.	50 %	50 %
Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50 %	50 %
Sealants (Protective Coating) Limited to one sealant per tooth every 36 months.	50 %	50 %

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers		
Space Maintainers Limited to one per 60 months. Benefit includes all adjustments within 6 months of installation.	50 %	50 %
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50 %	50 %
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50 %	50 %
Periodontal Surgery (Gum Surgery) Limited to one quadrant or site per 36 months per surgical area.	50 %	50 %
Scaling and Root Planing (Deep Cleanings) Limited to once per quadrant per 24 months.	50 %	50 %
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	50 %	50 %
Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars Limited to once per tooth per lifetime. Endodontic Surgery	50 %	50 %
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50 %	50 %
Oral Surgery, including Surgical Extraction	50 %	50 %
Adjunctive Services		
General Services (including Emergency Treatment of dental pain) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary.	50 %	50 %

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Occlusal guards for Insureds age 13 and older Limited to one guard every 12 months.	50 %	50 %
Major Restorative Services		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50 %	50 %
Fixed Prosthetics (Bridges) Limited to once per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50 %	50 %
Removable Prosthetics (Full or partial dentures) Limited to one per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50 %	50 %
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	50 %	50 %
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per 24 months.	50 %	50 %
Implants		
Implant Placement Limited to once per 60 months.	50 %	50 %
Implant Supported Prosthetics Limited to once per 60 months.	50 %	50 %
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to once per 60 months.	50 %	50 %
Repair Implant Supported Prosthesis by Report Limited to once per 60 months.	50 %	50 %
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to once per 60 months.	50 %	50 %

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Repair Implant Abutment by Support Limited to once per 60 months.	50 %	50 %
Radiographic/Surgical Implant Index by Report Limited to once per 60 months.	50 %	50 %
MEDICALLY NECESSARY ORTHODONTICS		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.		
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	50%	50%

Section 3: Pediatric Dental Exclusions

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy. Except as may be specifically provided under Section 2: Benefits for Covered Dental Services, benefits are not provided for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

Reimbursement for Dental Services

The Insured Person is responsible for sending a request for reimbursement to the Company, on a form provided by or satisfactory to the Company.

Claim Forms

It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began.
- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage the Insured Person must include the name of the other carrier(s).

To file a claim, submit the above information to the Company at the following address:

UnitedHealthcare Dental
Attn: Claims Unit
P.O. Box 30567
Salt Lake City, UT 84130-0567

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-877-816-3596. This number is also listed on the Insured's Dental ID Card.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

Covered Dental Service – a Dental Service or Dental Procedure for which benefits are provided under this endorsement.

Dental Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to the Insured Person while the policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dental Services Deductible - the amount the Insured Person must pay for Covered Dental Services in a Policy Year before the Company will begin paying for Network or Non-Network benefits in that Policy Year.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary Fees, as defined below.

Experimental, Investigational, or Unproven Service - medical, dental, surgical, diagnostic, 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, is determined to be:

- 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; or
- Subject to review and approval by any institutional review board for the proposed use; or
- 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; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

Foreign Services - services provided outside the U.S. and U.S. Territories.

Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Insured Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this endorsement. The definition of Necessary used in this endorsement relates only to benefits under this endorsement and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - a group of Dental Providers who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Insured Persons. The participation status of providers will change from time to time.

Network Benefits - benefits available for Covered Dental Services when provided by a Dental Provider who is a Network Dentist.

Non-Network Benefits - benefits available for Covered Dental Services obtained from Non-Network Dentists.

Usual and Customary Fee - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary Fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that the Company accepts.

Pediatric Vision Care Services Benefits

Benefits are provided for Vision Care Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) date the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-800-839-3242. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When Vision Care Services are obtained from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then seek reimbursement from the Company as described under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, the Insured Person will be required to pay any Copayments at the time of service.

Network Benefits
Benefits for Vision Care Services are determined based on the negotiated contract fee between the Company and the Vision Care Provider. The Company's negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Non-Network Benefits
Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

Policy Deductible
Benefits for pediatric Vision Care Services are not subject to any policy Deductible stated in the policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for Vision Care Services does not apply to the policy Deductible stated in the policy Schedule of Benefits.

Benefit Description
When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copayments and Coinsurance stated under each Vision Care Service in the Schedule of Benefits below.

Routine Vision Examination
A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well the Insured sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses - Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.
The following Optional Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames - A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Contact Lenses - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

The Insured Person is eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Insured Person selects more than one of these Vision Care Services, the Company will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	50% of the billed charge.
• Bifocal		100% after a Copayment of $40.	50% of the billed charge.
• Trifocal		100% after a Copayment of $40.	50% of the billed charge.
• Lenticular		100% after a Copayment of $40.	50% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - 160.		100% after a Copayment of $15.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - 200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - 250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.
Contact Lenses	Limited to a 12 month supply.		
• Covered Contact Lens Selection		100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses		100% after a Copayment of $40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy.

Except as may be specifically provided under Section 1: Benefits for Pediatric Vision Care Services, benefits are not provided for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in Section 1: Benefits for Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services
When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company.

Reimbursement for Vision Care Services
To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), the Insured Person must provide all of the following information at the address specified below:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):
248-733-6060

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Section 4: Defined Terms for Pediatric Vision Care Services
The following definitions are in addition to the policy DEFINITIONS:

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in Section 1: Benefits for Pediatric Vision Care Services.

Notice of Appeal Rights

RESOLUTION OF GRIEVANCES

Internal Inquiry Process

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

If the Insured has a complaint about a claim denial, the Insured may call our Member Services telephone number 1-800-977-4698 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. The Insured may not attend this review.
2. A decision will be made by the Claims Supervisor, within 3 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 958 CMR 3.300 through 958 CMR 3.313 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 958 CMR 3.300 through 958 CMR 3.313. 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 1-800-977-4698 by the Insured or the authorized representative for consideration by the grievance reviewer. An oral grievance made by the Insured or the authorized representative shall be reduced to writing by the Company and a copy forwarded to the Insured within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company.
2. Within 15 business days after the Company receives the Insured's request for an internal grievance review, the Company must provide the Insured with a written acknowledgment of the receipt of the grievance, except where an oral grievance has been reduced to writing by the Company or this time period is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company.
3. Any grievance that requires the review of medical records, shall include the signature of the Insured, or the Insured's authorized representative on a form provided promptly by the Company authorizing the release of medical and treatment information relevant to the grievance, in a manner consistent with state and federal law. The Insured and the authorized representative shall have access to any medical information and records relevant to the grievance relating to the Insured which is in the possession of and under the control of the Company. The Company shall request said authorization from the Insured when necessary for requests reduced to writing by the Company and for any written requests lacking said authorization.
4. The Insured may or may not attend this review but is not required to do so.

5. An internal grievance review written decision will be issued to the Insured and, if applicable, the Insured's provider, within 30 business days of the receipt of the grievance. When a grievance requires the review of medical records, the 30 business day period will not begin to run until the Insured or the Insured's authorized representative submits a signed authorization for release of medical records and treatment information as required in 958 CMR 3.302 (2). 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 958 CMR 3.300, 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 958 CMR 3.300 if earlier than the three business day time period. The time limits in 958 CMR 3.305 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 958 CMR 3.307 before an Insured's discharge from a hospital if the grievance is submitted by an Insured or the Insured's authorized representative while the Insured is an inpatient in a hospital.
2. Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the internal grievance process, within 48 hours (or earlier for durable medical equipment at the option of a Physician responsible for treatment or proposed treatment of the covered patient) of receipt of certification by said Physician that, in the Physician's opinion:
    a. the service or use of durable medical equipment at issue in grievance is Medically Necessary;
    b. a denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to the Insured; and
    c. such risk of serious harm is so immediate that the provision of such services of durable medical equipment should not await the outcome of the normal grievance process.
3. Provisions that require that, in the event a Physician exercises the option of automatic reversal earlier than 48 hours for durable medical equipment, the Physician must further certify as to the specific, immediate and severe harm that will result to the Insured absent action within the 48 hour time period.

Expedited Process for Insured with Terminal Illness

1. When a grievance is submitted by an Insured with a terminal illness, or by the Insured's authorized representative on behalf of said Insured, a resolution shall be provided to the Insured or said authorized representative within five business days from the receipt of such grievance.
2. If the expedited review process affirms the denial of coverage or treatment to an Insured with a terminal illness, the Company shall provide the Insured or the Insured's authorized representative, if any, within five business days of the decision:
   a. a statement setting forth the specific medical and scientific reasons for denying coverage or treatment.
   b. a description of alternative treatment, services or supplies covered or provided by the Company, if any.
3. If the expedited review process affirms the denial of coverage or treatment to an Insured with a terminal illness, the Company shall allow the Insured or the Insured's authorized representative, if any, to request a conference.
   a. The conference shall be scheduled within ten days of receiving a request from an Insured; provided however that the conference shall be held within five business days of the request if the treating Physician determines, after consultation with the Company's medical consultant or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by the Company, would be materially reduced if not provided at the earliest possible date.
   b. At the conference, the Company shall permit attendance of the Insured, the authorized representatives of the Insured, if any, or both.
   c. At the conference, the Insured and/or the Insured's authorized representative, if any, and a Company representative who has authority to determine the disposition of the grievance shall review the information provided to the Insured under 958 CMR 3.310 (2).
4. If the expedited review process set forth in 958 CMR 3.310 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 958 CMR 3.401 and, if the review involves the termination of ongoing services, the opportunity to request continuation of services pursuant to 958 CMR 3.414.

Failure to Meet Time Limits

A grievance not properly acted on by the Company within the required time limits required by 958 CMR 3.300 through 958 CMR 3.310 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 958 CMR 3.312, 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 958 CMR 3.309 (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 Commission;
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 958 CMR 3.402 unless waived by 958 CMR 3.402 (2).

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

The Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109
Toll-Free - 1-800-436-7757
FAX – 617-624-5046
www.mass.gov/hpc/opp/

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

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

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

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

The Plan is Underwritten by:
HPHC INSURANCE COMPANY
and Administered by UnitedHealthcare **Student**Resources

Administrative Office:
HPHC Insurance Company
c/o UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-977-4698
customerservice@uhcsr.com
claims@uhcsr.com

Sales/Marketing Services:
HPHC Insurance Company
c/o UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
1-800-237-0903

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 # 2015-202853-61.