PLEASE NOTE:

THIS DOCUMENT HAS CHANGED. PLEASE SEE THE BACK COVER FOR DETAILS

READ YOUR CERTIFICATE CAREFULLY

2011-2012

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed especially for the Students of

Wellesley College

Non-Renewable One Year Term Insurance

UnitedHealthcare®
A UnitedHealth Group Company

06-BR-MA PPO (Rev 09) 20-395-1

Wellesley College Health Service

This brochure briefly describes the health services and Student Injury and Sickness Insurance Plan available to Wellesley College students. At the heart of the program is the Wellesley College Health Service available to students enrolled at Wellesley College, as summarized below.

Students who enroll in the College sponsored Student Injury and Sickness Insurance Plan underwritten by UnitedHealthcare Insurance Company, also receive benefits for a covered Accident or Sickness as explained within the brochure for eligible medical care for which the student incurs charges, on or off campus, during the policy period for which premium has been paid.

This policy is required for students who do not already have comparable U.S. coverage and is strongly advised for all students, particularly for students whose home address is more than 200 miles away from campus and for student athletes.

About the Health Service

All Wellesley College students, including Davis Scholars and Exchange students, are encouraged to seek services at the Health Service. Students do not need to be covered by the Student Injury and Sickness Insurance Plan in order to use the Health Service. However, the Health Service does not provide services for College guests, dependents, campus visitors or campus employees.

The Wellesley College Health Center is open:
Monday thru Friday
from 9:00 a.m. – 5:00 p.m.
Appointments
from 9:00 a.m. - 4:00 p.m.

Monday Evenings

from 5:00p.m. - 7:00p.m. (by appointment)

Students are encouraged to call prior to visiting the Health Service. During semester breaks (winter and spring) students should seek treatment at the nearest facility or provider. If in the Wellesley area and the Health Service is not open, students should go to the MetroWest Medical Center for emergency services.

Services Available

The services provided by the Health Service are those which are usually available at a primary care facility, including gynecology. The Health Service consists of a state-licensed outpatient clinic, an accredited clinical laboratory, and a Health Education Resource Room. Clinical services are provided Nurse Practitioners, Registered Nurses and board-certified Physicians.

Health Service Charges

There is no charge to any student for routine outpatient care by a Health Service staff member. There are charges for laboratory tests, certain drugs/prescriptions and appliances, most (non-routine) procedures, most immunizations, and referral for X-ray and other consultation. A student is responsible for payment of these charges. A student who incurs charges for these treatments at the Health Service may elect to pay the bill herself or send it to her other insurance (i.e. parent's or spouse's medical insurance) for payment. If the bill is not paid within 45 days, charges are forwarded to the Student Financial Services, posted to the student's tuition account and due immediately.

For students enrolled in the College-sponsored Student Injury and Sickness Insurance Plan these services are covered under the Plan and there is no billing or paperwork to complete. However, all immunizations and some prescription medications are not covered under the Plan.

Confidentiality

The Health Service is very sensitive to the importance of confidentiality in the provider-patient relationship. Information is not released to College authorities, other colleges or agencies, or parents without the student's written authorization, except as required for insurance reimbursement or as required by law.

Health Service Referral Requirements - Students Only

If you are enrolled in the Student Injury and Sickness Insurance Plan and the Health Service is available, you must first seek the resources of the Health Service where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Health Service for which no prior approval or referral is obtained are excluded from coverage of the benefits otherwise payable under the Basic Medical Expense Schedule of Benefits. A referral issued by the Health Service must accompany the claim when submitted. A new referral is required at the beginning of each policy year.

A Health Service referral for outside care is not necessary only under the following conditions:

Exceptions to the Referral Requirement for Insured Students:

1. Medical Emergency. The Insured Student needs to return to the Health Service for necessary follow-up care;
2. When the Health Service is closed;
3. When service is rendered at another facility during break or vacation periods;
4. Medical care received when the Insured Student is more than 30 miles from campus;
5. Medical care received when the Insured Student is no longer able to use the Health Service due to change in student status;
6. Maternity, Obstetrics, Gynecology; or
7. Mental Disorders.

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Privacy Policy

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

Student Eligibility and Enrollment Information

All registered degree students, and all registered non-degree students in on-campus attendance and taking at least 3 units per semester 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 television (TV) courses do not fulfill the eligibility requirements that the Student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse, husband or wife and unmarried children under 19 years of age or 23 years, if a full-time dependent student at an accredited institution of higher learning, who are not self-supporting. dependent eligibility expires concurrently with that of the insured student.

All Insured students may purchase the Major Medical Coverage on an optional basis. Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment in the plan. Students may purchase optional coverages for themselves or for themselves and all family members.

Employees/Students of Wellesley College who are eligible to purchase its Employee Health Insurance are NOT eligible to purchase the Student Injury and Sickness Insurance Plan.

On-line Waiver Process

Eligible students are automatically enrolled in and billed for the Wellesley College Student Injury and Sickness Insurance Plan which meets the requirements of the Commonwealth of Massachusetts.

Student who are currently enrolled in a health insurance plan of comparable coverage that will be in effect until August 15, 2012 can elect to waive the Wellesley College Student Injury and Sickness Insurance Plan.

Recognizing that health coverage may change and as required by state law, at the beginning of each academic year students are asked to provide proof of comparable coverage before waiving the Wellesley College Student Injury and Sickness Insurance Plan.

Waiver Process

To document proof of comparable coverage an online waiver form must be completed and submitted by the deadline.

1. Log on to www.gallagherkoster.com/wellesley
2. Click on the "Log In" link (located on the top right of screen)

   First time users and Returning Students, must access the Online Waiver Form using the "Log In" feature. Your user account has already been created by Gallagher Koster and Wellesley College. Your username will be your school email address. Your password will be your student ID number.
3. Once logged in, click the red "I Want Waive" button. When waiving insurance, have your current health insurance ID card ready as you will need this information n order to complete the waiver form.

To complete the online waiver form, you will need to provide information from your current health insurance card: name, claims address, and toll-free customer service number of the insurance carrier, the name of the policyholder and policyholder ID or group number.

Immediately upon submitting the On-line Waiver form, you will receive a confirmation number indicating that the form has been submitted. Print this confirmation number for your records as it is your documentation that the form was submitted. If you do not receive a confirmation number, you will need to correct any errors and resubmit the form. The online process is the only accepted process for waiving coverage.

Wellesley College reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that is not comparable coverage the student will be automatically enrolled in the Wellesley College Student Injury and Sickness Insurance Plan, effective the date that the determination was made and there will be no pro-rate of premium.

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

In the event students waive the Student Injury and Sickness Insurance Plan and then lose current coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage. For petitions received after the 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Koster and the premium will be prorated.

Waiver Deadline

The deadline for students to complete the Online Waiver Form for annual coverage is August 1, 2011 and January 2, 2012 for students newly enrolled for the Spring Semester. Students who waive the Student Injury and Sickness Insurance Plan in the fall waive coverage for the entire policy year. The Online Waiver process is the only accepted process for making your insurance selection. **Students who do not submit the Online Waiver Form by the deadline will remain enrolled in and billed for the Wellesley College student Injury and Sickness Insurance Plan.**

Optional Major Medical Enrollment Information

The enrollment deadline is September 15, 2011 for Annual Coverage and February 1, 2012 for newly enrolled students for Spring Semester. Enrollment forms received after the deadline will not be accepted. Students interested in enrolling in the Optional Major Medical Benefit can enroll online at www.gallagherkoster.com/wellesley or contact Gallagher Koster for an enrollment form. Please see page 11 for further details.

Dependent Eligibility and Enrollment Information

Insured Students may also enroll their eligible Dependents. Eligible Dependents are the spouse, (husband or wife) of the Named Insured and their unmarried children under 19 years of age or 23 years if a full-time dependent student at an accredited institution of higher learning who are not self-supporting. Dependent eligibility expires concurrently with that of the insured student.

Dependent enrollment coverage is not automatic; it must be requested and renewed each year. There are two ways to submit dependent enrollment information. You can contact Gallagher Koster to obtain a Dependent Enrollment Form or you can enroll eligible Dependents online at www.gallagherkoster.com/wellesley. Create a User Account or if already created, log on through "Returning Users", and then select the 2011-2012 Dependent Enrollment Form. Payment for Dependent coverage is in addition to the fee for your individual student coverage. The deadline for Dependent enrollment for annual coverage is September 15, 2011 and the deadline for Dependent enrollment for students newly enrolled for the Spring Semester is February 1, 2012. If the deadline is not met, the effective date will be the postmark date on the envelope or the date the online Dependent Enrollment Form is submitted. The premium will not be prorated. It is the Insured Student's responsibility to enroll eligible Dependents each year.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 15, 2011. Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment and full premium is received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 14, 2012. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

1. **Annual Term Students:** Coverage for all Insured Students enrolled for the Fall Semester will become effective on August 15, 2011 and will terminate on August 14, 2012.
2. **New Spring Semester Students:** Coverage for all Insured Students enrolled for the Spring Semester will become effective on January 1, 2012, and will terminate on August 14, 2012.

Dependent coverage will not be effective prior to that of the insured student or extend beyond that of the insured student.

Premium Rates for Student Health Insurance Plan

***The Premium Rates include an Administrative Fee.**

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

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

	Annual 08/15/11 - 08/14/12	Spring Semester 01/01/12-08/14/12
Student*	$1,615.00	$1,046.00
Spouse	$2,497.00	$1,579.00
Child(ren)	$1,941.00	$1,228.00

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

Premium Refund Policy

Except for a medical leave or withdrawal due to a covered Injury or Sickness, any Insured Student withdrawing from the College during the first 31 days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of the premium will be made. Insured Students withdrawing after 31 days will remain covered under the Plan for the full period for which the premium has been paid and no refund will be made available.

All premiums are payable in advance for each policy term in accordance with the Company's Premium rates. The full premium must be paid even if the correct premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees, except as required by law. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the Armed Forces.

Involuntary Disenrollment Rate

The involuntary disenrollment rate for insureds in Massachusetts for UnitedHealthcare Insurance Company for 2010 was 0%.

Extension of Benefits after Termination

The coverage provided under this Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date. The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

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

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.

Complaint Resolution

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

Schedule of Basic Medical Expense Benefits

INJURY AND SICKNESS BENEFITS

Maximum Benefit $100,000 for each Injury or Sickness

Coinsurance: Preferred Providers 100% except as noted below

Coinsurance: Out-of-Network 80% except as noted below

The Preferred Provider for this Plan is UnitedHealthcare Options PPO.

The policy provides benefits as shown below for loss incurred by an Insured due to a covered Injury or Sickness up to the policy Maximum Benefit of $100,000 for each Injury or Sickness. If care is received from a Preferred Provider, any Covered Medical Expenses will be paid at the applicable Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. (See Medical Emergency Treatment on page 25 for additional information). In all other situations, reduced, or lower benefits will be provided when an Out-of-Network provider is used.

Exclusion #14 will not apply to nasal surgery required as a result of a Covered Injury.

Please refer to page 40 for Claims Processing Procedures.

Benefits will be paid up to the Maximum Benefit for each service scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network benefit maximums, unless noted below.

NOTE: Although the Maximum Benefit per Injury or Sickness is $100,000, there are some specific benefit limitations as identified in the Schedule.

Covered Medical Expenses include:

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

Inpatient	Preferred Providers	Out-of-Network Providers
Room and Board Expense, daily semi-private room rate; and general nursing care provided by the Hospital.	100% of PA	80% of U&C
Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.	100% of PA	80% of U&C
Intensive Care	100% of PA	80% of U&C

Inpatient	Preferred Providers	Out-of-Network Providers
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	100% of PA	80% of U&C
Assistant Surgeon	30% of Surgery Allowance	
Anesthetist, professional services in connection with inpatient surgery.	30% of Surgery Allowance	
Registered Nurse's Services, private duty nursing care.	100% of PA	80% of U&C
Physician's Visits, benefits do not apply when related to surgery.	100% of PA	80% of U&C
Pre-Admission Testing, payable within 7 working days prior to admission.	100% of PA	80% of U&C
Physiotherapy	100% of PA	80% of U&C
Routine Newborn Care	See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care (pg. 15)	
Mental Disorders	See Benefits for Treatment of Mental Disorders (pg. 18-19)	
Outpatient		
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	100% of PA	80% of U&C
Assistant Surgeon	30% of Surgery Allowance	
Anesthetist, professional services administered in connection with outpatient surgery.	30% of Surgery Allowance	
Physician Visits, benefits for Physician Visits do not apply when related to surgery or Physiotherapy. ***$10 copay for Students, $25 copay for Dependents***	100% of PA	80% of U&C

Outpatient	Preferred Providers	Out-of-Network Providers
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital including the cost of the operating room, laboratory tests and x-ray examinations, including professional fees, anesthesia, drugs or medicines, and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	100% of PA	80% of U&C
Physiotherapy, benefits are limited to one visit per day. *(Review of Medical Necessity will be performed after 12 visits Per Injury or Sickness)*	100% of PA	80% of U&C
Medical Emergency Expenses, Benefits will be paid for the attending Physician's charges, x-rays, laboratory procedures, injections, the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. ***$25 copay for Students, $100 copay for Dependents for visits that do not result in Hospital Confinement.***	100% of PA	100% of U&C
Diagnostic X-ray & Laboratory Services	100% of PA	80% of U&C
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's visits, physiotherapy, x-rays and laboratory procedures.	100% of PA	80% of U&C
Chemotherapy & Radiation Therapy	100% of PA	80% of U&C
Injections, when administered in the Physician's office and charged on Physician's statement. *(Does not include immunizations. Refer to Wellness Benefit).*	100% of PA	80% of U&C
Prescription Drugs, and medicines lawfully obtainable only upon written prescription of a Physician. Mail order Prescription Drugs through UnitedHealthcare Network Pharmacy at 2.5 times the retail copay up to a 90-day supply per prescription subject to the Prescription Drug maximum benefit. (***$2,000 maximum Per Policy Year)***	UnitedHealthcare Network Pharmacy (UHPS) $10 copay per prescription for Tier 1 / $20 copay per prescription for Tier 2 / up to a 31 day supply per prescription	No Benefits
Mental Disorders	See Benefits for Treatment of Mental Disorders (pg. 18-19)	

Other	Preferred Providers	Out-of-Network Providers
Ambulance	100% of U&C	100% of U&C
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	100% of U&C	100% of U&C
Consultant Physician Fees, when requested and approved by the attending Physician.	Paid under Physician's Visits	
Dental Treatment, made necessary by Injury to Sound, Natural Teeth and removal of unerupted impacted wisdom teeth. ***$75 maximum per tooth***	100% of U&C	100% of U&C
Maternity	See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care (pg. 15)	
Complications of Pregnancy	Paid as any Other Sickness	
Elective Abortion	Paid as any Other Sickness	
Alcoholism/Drug Abuse (Substance Abuse)	See Benefits for Treatment of Mental Disorders (pg. 18-19)	
Intercollegiate Sports	Paid as any other Injury	
Second Surgical Opinion	100% of PA	80% of U&C
High Cost Procedures, *(For outpatient procedures costing over $200, including but not limited to C.A.T. Scan, Magnetic Resonance Imaging (MRI) and Laser Treatments)*	100% of PA	80% of U&C
Wellness Benefit, benefits include one annual physical Per Policy Year with routine screening, allergy injections and immunizations including HPV. ***$500 maximum Per Policy Year***	70% of PA	50% of U&C
Hospital Outpatient Department Visit, ***$25 copay for Students, $50 copay for Dependents***	100% of PA	80% of U&C
Repatriation	Benefits provided by Scholastic Emergency Services, Inc.	
Medical Evacuation	Benefits provided by Scholastic Emergency Services, Inc.	

UnitedHealthcare Network Pharmacy Benefits

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

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

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

$20 copay per prescription order or refill for a Tier 2 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.

Your maximum allowed benefit is $2,000 Per Policy Year.

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

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

Additional Exclusions

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

Definitions

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

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service at1-877-417-7345.

Preferred Provider Information

The UnitedHealthcare Options PPO 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 healthcare providers who participate in UnitedHealthcare Options PPO.

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

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

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

Inpatient Hospital Expenses

Preferred Hospitals – Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at 100% up to any limits specified in the Schedule of Benefits. Call (866) 948-8472 for information about Preferred Hospitals.

Out-of-Network Hospitals - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by Preferred Providers 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.

Optional Major Medical Benefit

$225,000 Maximum Benefit (For each Injury or Sickness)

This optional benefit is subject to payment of an additional premium as specified on the enrollment card. Optional benefits may only be purchased at the time of initial enrollment in the Plan and may not be added later.

The Major Medical Benefit begins payment after the Basic Maximum Benefit of $100,000 has been paid by the Company. The Company will pay 100% for additional Covered Medical Expenses incurred up to the Major Medical Maximum of $225,000. The total benefit payable under Major Medical is $325,000 minus the Basic Benefits already paid.

No Benefits will be paid under Major Medical for:

1. Room & Board expenses which exceed the semi-private room rate;
2. Dental treatment; and
3. Pre-existing Conditions, except for individuals who have been continuously insured under Optional Major Medical Coverage for at least six consecutive months; or under a previous qualifying health plan, provided such coverage was in force within 30 days prior to the Insured's Effective Date under this policy.

Maternity Testing

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered 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; and Coombs test; **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); **Once during second or third trimester** – 50g Glucola (blood glucose 1 hour postprandial); and **Once during third trimester** - Group B Strep Culture. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-866-948-8472.

Mandated Benefits

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 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 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. 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.

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

Benefits for Prosthetic Devices and Repairs

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

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

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

Benefits for Enteral Formula

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

Benefits shall be subject to a copayment for a 30-day supply of enteral formula that is equal to the copayment required for outpatient Physician Visits. Benefits shall be subject to all Deductible,copayment, coinsurance, limitations or any other provisions of the policy.

Benefits for Home Health Care Services

Benefits will be paid the same as any other Sickness for Home Health Care Services. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aid and the use of durable medical equipment and supplies shall be provided to the extent such services are determined to be a Medically Necessary component of said nursing and physical therapy. Benefits for Home Health Care Services are payable only when such services are Medically Necessary and provided in conjunction with a Physician approved Home Health Care Services plan.

Durable medical equipment and supplies provided as part of an approved Home Health Care Services plan will not be subject to any policy limitations regarding durable medical equipment and supplies. "Home health care services" means health care services for an Insured Person by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a patient's residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services. Said services shall include, but not be limited to, nursing and physical therapy.

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

Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services

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

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

Benefits for Hospice Care

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

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

Benefits for 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 Infertility Treatment

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Infertility for Insured Persons residing within the Commonwealth of Massachusetts to the same extent that benefits are provided for other pregnancy-related procedures. Benefits will include, but not be limited to, the following Non-experimental Infertility Procedures: 1) Artificial Insemination (AI); 2) In Vitro Fertilization and Embryo Placement (IVF-EP); 3) Gamete Intra-Fallopian Transfer (GIFT); 4) Sperm, egg and/or inseminated egg procurement, processing and banking, to the extent such costs are not covered by the donor's insurer, if any; 5) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility; and 6) Zygote Intrafallopian Transfer (ZIFT).

Benefits are not provided for the following Experimental Infertility Procedures: 1) Any Experimental Infertility Procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner; 2) Surrogacy; 3) Reversal of Voluntary Sterilization; and 4) Cryopreservation of eggs.

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

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

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

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

Benefits for Initial Prosthetic Device and Reconstructive Surgery

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

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

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

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

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

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

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.

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 Qualified Clinical Trials for Treatment of Cancer

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

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

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

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

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

Benefits for Treatment of Diabetes

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

Benefits will be paid for the following, subject to any applicable Deductibles, co-payments and coinsurance shown on the Schedule of Benefits:

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

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

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

Benefits for 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 Examination

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

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

Benefits for Off-Label Drug Use

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

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

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

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

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

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

Benefits for Treatment of Mental Disorders

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

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

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

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

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

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

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

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of all other Mental Disorders not otherwise provided for in this benefit section and which are described in the most recent edition of DSM during each 12 month period but shall never exceed:

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

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

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

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

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

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

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

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

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

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

Benefits for Scalp Hair Prostheses

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

Benefits are limited to $350 per Policy Year.

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

Benefits for Hypodermic Syringes or Needles

Benefits will be paid for the Covered Medical Expenses incurred for medically necessary hypodermic syringes and needles.

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

Benefits for Christian Science Services

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

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

Benefits for Treatment of Speech, Hearing and Language Disorders

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

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

Definitions

ADOPTED OR ADOPTIVE CHILD means: 1) a child from the date of the filing of 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.

COMPLICATION OF PREGNANCY means a condition 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy. The term "complication of pregnancy" includes non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; hyperemesis gravidarum; and pre-eclampsia.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any. Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

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

DEPENDENT means the spouse (husband or wife) of the Named Insured and their dependent, unmarried children and any Newborn Infant of a dependent of the Named Insured. Children shall cease to be dependent on the first to occur of: 1) The end of the month in which they marry; or 2) The end of the month in which they attain the age of nineteen (19) years or 23 years, if a full-time dependent student at an accredited institution of higher learning. 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; and,
2) Chiefly dependent upon the Insured Person for support and maintenance.

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

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

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

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

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

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

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

INJURY means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

INSURED PERSON means: 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 designed facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care does not mean any of these step-down units: 1) Progressive care; 2) Sub-acute intensive care; 3) Intermediate care units; 4) Private monitored rooms, 5) Observation units; or 6) Other facilities which do not meet the standards for Intensive Care.

MEDICAL EMERGENCY means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine, to result in 1) placing the health of the Insured Person in serious jeopardy; 2) serious impairment to body function, or serious dysfunction of any body organ or part; or 3) with respect to a pregnant woman, the health of the woman or her unborn child.

MEDICAL NECESSITY or MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are: 1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury; 2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury; 3) In accordance with the standards of good medical practice; 4) Not primarily for the convenience of the Insured, or the Insured's Physician; and, 5) The most appropriate supply or level of service which can safely be provided to the Insured. The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient. This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

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

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

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

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

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

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

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

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

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

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

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. 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.

Excess Provision

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, this Excess Provision will not be applied to the first $100 of Covered Medical Expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

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:

1. Congenital conditions, except as specifically provided for Newborn or Adopted Infants;
2. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
3. Dental treatment, except as specifically provided in the Schedule of Benefits;
4. Elective Surgery or Elective Treatment;
5. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
6. Hearing examinations or hearing aids; or other treatment for hearing defects and problems, except as specifically provided in the policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
7. 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;
8. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

9. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
10. Prescription Drugs, services or supplies as follows:
    a. Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
    b. Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
    c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the policy;
    d. Products used for cosmetic purposes;
    e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f. Anorectics - drugs used for the purpose of weight control;
    g. Sexual enhancement drugs, such as Viagra;
    h. Growth hormones; or
    i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
11. Impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery;
12. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
13. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
14. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof;
15. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
16. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and
17. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

Medical Emergency Treatment

In the event of Injury or Sickness, the Insured should contact their Physician or report to the Student Health Service if such services are available to the Insured. Should the Insured have a condition that a prudent lay person would consider a Medical Emergency, the Insured should go to the nearest Physician or Hospital or call the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent. An Insured is not required to contact the Company prior to treatment.

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

Scholastic Emergency Services: Global Emergency Medical Assistance

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

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

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

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

Key Services include:

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

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

To access services please call:

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

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

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

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

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

Managed Care Information Provisions

Provider Directories

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

a) by calling UnitedHealthcare StudentResources at 1-866-948-8472; or

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

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

Service Area Description

All counties in Massachusetts are included in the UnitedHealthcare Options PPO Network.

Continuity of Coverage

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

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

Resolution of Grievances

Internal Inquiry Process

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

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

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

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

Internal Grievance Review

1. The internal grievance material must be submitted in writing, by electronic means at info@uhcsr.com or by calling our Member Services telephone number 1-866-948-8472 by the Insured or his/her provider for consideration by the grievance reviewer. An oral grievance made by the Insured or the authorized representative shall be reduced to writing by us and a copy thereof forwarded to the Insured by us within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and us.
2. Within 15 business days after we receive your request for an internal grievance review, we must provide you with the name, address and telephone number of the grievance coordinator and information on how to submit written material, except where an oral grievance has been reduced to writing by us or this time period is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and us.
3. Any grievance that requires the review of medical records, shall include the signature of the Insured, or the Insured's authorized representative on a form provided promptly by us authorizing the release of medical and treatment information relevant to the grievance to us, in a manner consistent with state and federal law. The Insured and the authorized representative shall have access to any medical information and records relevant to the grievance relating to the Insured which is in the possession of us and under our control. We shall request said authorization from the Insured when necessary for requests reduced to writing by us and for any written requests lacking said authorization.
4. The Insured may or may not attend this review but is not required to do so.
5. An internal grievance review written decision will be issued to the Insured and, if applicable, the Insured's provider, within 30 days of the receipt of the grievance. When a grievance requires the review of medical records, the 30 business day period will not begin to run until the Insured or the Insured's authorized representative submits a signed authorization for release of medical records and treatment information as required in 105 CMR 128.302(B). In the event that the signed authorization is not provided by the Insured or the Insured's authorized representative, if any, within 30 business days of the receipt of the grievance, we may, in our discretion, issue a resolution of the grievance without review of some or all of the medical records. The 30 business day time period for written resolution of a grievance that does not require the review of medical records, begins on the day immediately following the three business day time period for processing inquiries pursuant to 105 CMR 128.200, if the inquiry has not been addressed within that

period of time; or on the day the Insured or the Insured's authorized representative, if any, notifies the carrier that s/he is not satisfied with the response to any inquiry under 105 CMR 128.200 if earlier than the three business day time period. The time limits in 105 CMR 128.305 may be waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and us. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be an actively practicing Physician in the same or similar specialty who typically treat the medical condition, perform or provide the treatment that is the subject of the grievance to evaluate the matter. The written decision issued in a grievance review shall contain:

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

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

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

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

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

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

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

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

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

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

Grievance Decision Reconsideration

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

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

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

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

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

Expedited Grievance Review

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

1) A written resolution pursuant to 105 CMR 128.307 before an Insured's discharge from a Hospital if the grievance is submitted by an Insured or the Insured's authorized representative while the Insured is an inpatient in a Hospital.
2) Provisions for the automatic reversal of decisions denying coverage for services or Durable Medical Equipment, pending the outcome of the internal grievance process, within 48 hours (or earlier for durable medical equipment at the option of a Physician responsible for treatment or proposed treatment of the covered patient) of receipt of certification by said Physician that, in the Physician's opinion:
   a) the service or use of Durable Medical Equipment at issue in grievance is Medically Necessary;
   b) a denial of coverage for such services or Durable Medical Equipment would create a substantial risk of serious harm to the Insured; and
   c) such risk of serious harm is so immediate that the provision of such services of Durable Medical Equipment should not await the outcome of the normal grievance process.
3) Provisions that require that, in the event a Physician exercises the option of automatic reversal earlier than 48 hours for Durable Medical Equipment, the Physician must further certify as to the specific, immediate and severe harm that will result to the Insured absent action within the 48 hour time period.

Expedited Process for Insured with Terminal Illness

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

4) If the expedited review process set forth in 105 CMR 128.310 results in a final adverse determination, the written resolution will inform the Insured or the Insured's authorized representative of the opportunity to request an expedited external review pursuant to 105 CMR 128.401 and, if the review involves the termination of ongoing services, the opportunity to request continuation of services pursuant to 105 CMR 128.414.

Failure to Meet Time Limits

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

Coverage or Treatment Pending Resolution of Internal Grievance

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

External Review

Any Insured or authorized representative of an Insured who is aggrieved by a final adverse determination issued by us may request an external review by filing a request in writing with the Office of Patient Protection within 45 days of the Insured's receipt of written notice of the final adverse determination.

If the external review involves the termination of ongoing services, the Insured may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to the Insured's health may result absent such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage shall be at UnitedHealthcare Insurance 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 to the Office of Patient Protection which shall accompany the request for a review. The fee may be waived by the Office of Patient Protection if it determines that the payment of the fee would result in an extreme financial hardship to the Insured.

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

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

a. be on a form prescribed by the Department;
b. include the signature of the Insured or the Insured's authorized representative consenting to the release of medical information;
c. include a copy of the written final adverse determination issued by us; and,
d. include the $25 fee required pursuant to 105 CMR 128.402.

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

The Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
250 Washington Street, 2nd Floor
Boston, MA 02108
Toll-Free - 1-800-436-7757
FAX – 617-624-5046
www.state.ma.us/dph/opp/

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

UnitedHealthcare Insurance Company provides the following information to the Office of Patient Protection no later than May 15 of each year:

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

Physician Profiling

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

Utilization Review

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

You may contact the Customer Service Department at 1-800-767-0700 if you have questions concerning the status of a claim.

Utilization Review Program

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

Responsibility:

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

The Company delegates certain functions to an outside certified Medical Review, as described below, and relies on the experience and qualifications of such Medical Review personnel to make final utilization review determinations.

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

Review Process:

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

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

Appeals:

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

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

Oversight:

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

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

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

We will require a semiannual report of the reviews that the Medical Review Organization has completed and the outcomes (including any appeals actions) of those reviews. These reports will be reviewed by the Quality Improvement and Management Committee appointed by the Company to determine if any concerns exist concerning decisions made by the Medical Review Organization (for example, patterns of adverse determination reversed upon appeal). In addition, the medical standards of practice and published clinical criteria used by the Medical Review Organization in making its determinations will be reviewed by the Utilization Review Committee to review/compare the decisions made by the Medical Review Organization 3.

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 standard expert published criteria as decided by the Company's Independent Review Organization. The Company adheres to clinical guidelines determined by its external Independent Review Organization Physician.

Quality Assurance

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

Quality Improvement and Management Program

The Company strives to continuously improve the services we provide. The Company's Quality Improvement and Management Program (QIMP) establishes the standards that encompass all quality improvement activities within the organization. The Company considers its customers to be the both the educational institutions and the individual students for whom we administer insurance plans.

Program Description:

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

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

- **Maintain compliance with local, state and federal regulatory requirements and accreditation standards.**
  - Monitor compliance with regulatory requirements for quality improvement and risk management opportunities and respond as needed.
  - Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.

Selection and Monitoring of PPO Network:

The Company uses UnitedHealthcare PPO Networks and the United Behavioral Health (UBH) Network for access to providers by the Company's Insureds in the Commonwealth of Massachusetts.

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

The Company's goal is to ensure that its Insureds/enrollees have access to an adequate number of PPO Network providers and practitioners on a timely basis.

UnitedHealthcare's National Credentialing Center (NCC) is responsible for the functions of selection and credentialing / recredentialing of PPO Network providers and practitioners to the PPO Network. The NCC is certified by the National Committee for Quality Assurance (NCQA) through national health plan reviews and outsources the application gathering process to CAQH (Council for Affordable and Quality Healthcare) and Primary Source Verification (PSV) to Aperture, a Certified Verification Organization (CVO). The Company monitors the PPO Network through its Quality Improvement and Management Program.

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

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

The Company's Managed Care Department has responsibility for operational oversight of the UHC PPO Networks. The Company applies the following criteria to the PPO upon selection:

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

Monitoring Activities for PPO Networks:

The Company uses UnitedHealthcare PPO Networks and the United Behavioral Health (UBH) Network. The Company's role in the QIMP includes monitoring and oversight practices described below. The Company must maintain a policy and procedure regarding the review process of the PPO Networks.

UnitedHealthcare completes a review of the PPO Network on an annual basis through the national UHC Quality Improvement Program. The results of the annual reviews will be reviewed by the Company's QIMP Committee.

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

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

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

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

Availability and Accessibility Standards:

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

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

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

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

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

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

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

Access:

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

Health Standards

Urban Areas:

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

Suburban Areas:

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

Rural Areas:

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

Behavioral Health Standards

Urban Areas:

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

Suburban Areas:

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

Rural Areas:

One therapist and one Hospital within 100 miles of Insured's residence.

The Company will review cases in which an Insured is not reasonably able to access a network provider on a case-by-case basis. In a situation where an Insured cannot reasonable access a network provider due to access-related issues, benefits for Covered Medical Expenses provided by a non-network provider will be provided at the in-network level of benefits.

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

Appointment Times

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

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

Telephone Access:

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

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

Behavioral Health Care:

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

Obtaining Health Care

In the event of Injury or Sickness, the student should:

1. If at Wellesley College, report to the Health Center for treatment or referral; or
2. If away from Wellesley College, seek treatment from the nearest Physician or Hospital;

Claim Procedure

Students should:

1. mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the college under with the student is insured. A company claim form is not required for filing a claim.
2. File claim within 30 days of Injury or first treatment of a Sickness. Bills should be received the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.
3. Benefits will be paid within forty-five (45) days of receipt of a claim. If payment is not made, the Company will notify the Insured in writing specifying the reasons for the nonpayment or what additional documentation is necessary for payment of the claim. If the Company fails to comply with the terms of this provision, in addition to any benefits payable, interest on such benefits will accrue beginning forty-five (45) days after the Company's receipt of the claim at a rate of one and one-half (1½) percent per month, not to exceed eighteen (18) percent per year. The interest payments shall not apply to a claim which the Company is investigating because of suspected fraud.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Submit all Claims to:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025

For information on a specific claim or to check the status of a claim, please contact:

UnitedHealthcare **StudentR**esources
P.O. Box 809025
Dallas, TX 75380-9025
gkclaims@uhcsr.com
1-866-948-8472

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

This Certificate is based on Policy # 2011-395-1

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Gallagher Koster Complements

These plans are not underwritten by UnitedHealthcare Insurance Company.

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

EyeMed Vision Care

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

Basix Dental Savings

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

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

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on our website, www.basixstudent.com.
- Tell the dental office that you are an insured student and have to the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility. If the office needs to check eligibility, call Gallagher Koster at (800) 471-7069.
- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts. for your school. You may also contact us via email from our website, or by telephone at (888) 274-9961.

Full details of the program can be viewed at the website: www.basixstudent.com. Once at the home page, select the link

CampusFit

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

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

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

Questions? Need More Information?

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

Gallagher Koster
500 Victory Road
Quincy, MA 02171
1-800-471-7069
Email: WellesleyStudent@gallagherkoster.com
www.gallagherkoster.com/wellesley

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

For information on the prescription drug program or to check on the status of a prescription drug claim, please contact:

UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, TX 75380-9025
1-866-948-8472

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2011-395-1

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

NOC 1

- Page i – Added evening hours to Health Center
- Page i, Services Available – last sentence changed **FROM**: "Clinical services are provided by board-certified physicians and nurse practitioners" **TO**: "Clinical services are provided by Nurse Practitioners, Registered Nurses and board certified Physicians."
- Page i, Health Services – change last line **FROM**: If the bill is not paid within 60 days, charges are forwarded to the Student Financial Services, posted to the student's tuition account and due immediately. **TO**: If the bill is not paid within 45 days, charges are forwarded to the Student Financial Services, posted to the student's tuition account and due immediately