



MARKEL INSURANCE COMPANY

TEN PARKWAY NORTH
DEERFIELD, IL 60015

A STOCK COMPANY

CERTIFICATE OF INSURANCE

This *Certificate of Insurance* provides a description of the benefits provided for Endicott College under the Blanket Accident and Sickness Policy shown below. The benefits described are subject to all of the terms and conditions of the Blanket Policy.

This certifies that **Markel Insurance Company** has issued the Policy number shown below to the College or University shown below.

04200348

Endicott College

Effective Date: 8/19/04

Expiration Date: 8/19/05

Markel Insurance Company

President

Secretary

VALIDATION OF COVERAGE:

This certificate alone is not proof of coverage. Proof of coverage for insured students at the institution is provided via a valid Identification Card (ID card), which is issued by Markel or Markel's representative.

Please refer to the Schedule of Benefits Appendix (located at the end of this book) for plan maximums, copayments, applicable deductibles, coinsurance and other important benefit information.

MAHMA500 (1/02)

INTERPRETATION SERVICES

We provide assistance in understanding the Plan’s administrative procedures to people whom English is a second language. If you need assistance, please call Pioneer at (413) 539-9900 or (800) 423-4586 and ask your Customer Service Representative for an interpreter. This interpreter (who is not an employee of Pioneer) will assist you in getting your questions answered.

Servicios de Interpretación

Ayudamos a personas para quienes el inglés es su segundo idioma a comprender los procedimientos administrativos del Plan. Si necesita asistencia, por favor comuníquese con Pioneer al (413) 539-9900 o al (800) 423-4586 y solicite los servicios de un intérprete a su Representante del Servicio de Atención al Cliente. Este intérprete (que no es un empleado de Pioneer) le ayudará a obtener las respuestas a sus preguntas.

Serviços de interpretação

Para uma melhor compreensão dos procedimentos administrativos do nosso Plano, nós oferecemos assistência às pessoas para as quais o Inglês é a segunda língua. Se necessitar de ajuda, contate a Pioneer no (413) 539 9900 ou no (800) 423 4586 e peça ao Representante do Serviço à Clientela para fornecer-lhe os serviços de um intérprete. Este intérprete, que não é um empregado da Pioneer, vai ajudar-lhe a obter as respostas adequadas às suas questões.

Servizi di interpretariato

Forniamo un servizio di assistenza affinché la comprensione delle procedure amministrative del programma sia garantita anche a chi non è madrelingua inglese. Chi avesse bisogno di tale assistenza è pregato di contattare la Pioneer al (413) 539-9900 o al numero verde (800) 423-4586 e di richiedere un interprete al Responsabile servizi alla clientela (Customer Service Representative). L’interprete (che non è un dipendente della Pioneer) vi aiuterà a trovare una risposta a tutte le vostre domande.

Sèvis Entèprèt

Moun ke angle se dezièm lang-yo, nou ede yo konpran kijan Plan administratif-la fonksyone. Si ou bezwen nou ede'w, rele Pioneer nan nimero (413) 539-9900 oswa nan nimero (800) 423-4586 epi mande reprezantan ki bay cliyan-yo sèvis-la pou li fè ou pale ak yon moun ki pale menm lang ak ou. Moun sa-a ki pale menm lang ak ou-a (ki pa yon anplwaye Pioneer) ap ede'w jwen repons pou tout keksyon ou vle pose.

Services d'interprétation

Pour bien comprendre les procédures administratives du Plan, nous fournissons de l'aide aux gens pour qui l'anglais n'est pas la langue maternelle. Si vous avez besoin d'aide, veuillez appeler Pioneer au (413) 539-9900 ou au (800) 423-4586 et demandez à un représentant du service à la clientèle de vous fournir un interprète. Cet interprète (qui ne travaille pas pour Pioneer) vous aidera à obtenir les réponses à vos questions.

Переводческие услуг

Мы оказываем помощь в понимании административных процедур Плана тем, для кого английский не является родным языком. Если Вам необходима данная помощь, пожалуйста, обратитесь в компанию Pioneer по телефону: (413) 539-9900, либо (800) 423-4586, и попросите Представителя по связям с клиентами (Customer Service Representative) о предоставлении устного переводчика. Данный переводчик (который не является сотрудником компании Pioneer) поможет Вам получить ответы на интересующие Вас вопросы.

口譯服務

我們為英語是第二語言的顧客提供口譯服務，幫助瞭解方案的行政程序。倘若您需要協助，請致電Pioneer，號碼是(413)539-9900或(800)423-4586，要求您的客服代表聯絡口譯員上線。這位口譯員(非Pioneer員工)會協助翻譯您的問題與答案。

ການບໍລິການຄຳແປພາສາ

ພວກເຮົາໃຫ້ການຊ່ວຍເຫຼືອໃນການເຂົ້າໃຈ ການປະຕິບັດຕໍາການບໍລິຫານຂອງພວກ ສ່າງຜູ້ທີ່ພາສາອັງກິດແມ່ນພາສາທີ່ສອງ. ຖ້າທ່ານຕ້ອງການຊ່ວຍເຫຼືອ, ກະລຸນາຕິດໂທຫາພາບປະສານ (Pioneer) ທີ່ເບີໂທ (413) 539-9900 ຫຼື (800) 423-4586 ແລະຂໍອໍານວຍພາສາກັບ ຜູ້ຊ່ວຍເປັນບໍລິການຊຸກຄັ້ງຂອງທ່ານ. ພາບພາສາທີ່ ຊື່ງຊື່ພວມແມ່ນບໍ່ຕ້ອງການຂອງ Pioneer ຈະໃຫ້ການຊ່ວຍເຫຼືອທ່ານ ຊອກຫາຄຳຕອບທີ່ໃຫ້ກັບຄຳຖາມຂອງທ່ານ.

ការបំរើផ្នែកភាសា

ເພើងអាចជួយលោកអ្នក ដែលភាសាម៉ដ្ឋេស ជាភាសាទីពីរ ឲ្យយល់ដឹងពីទំរង់ការគ្រប់គ្រង មានក្នុង កំរោងផែនការ បាន។ ប្រសិនបើ អ្នកត្រូវការជំនួយនេះ សូមទូរស័ព្ទទៅ Pioneer លេខ: (៨១៣) ៥៣៩- ៩៩០០ ឬ ៧៧៧៧៧៧ លេខ: (៨០០) ៤២៣-៤៥៨៦ ហើយសួររក បុគ្គលិកបំរើផ្នែកភាសា ដើម្បីអ្នក បកប្រែ។ អ្នកបកប្រែ (ដែលមិនមែនជាធិបតី របស់ Pioneer) នឹងជួយអ្នក រកចម្លើយ ដែលអ្នកចង់សួរ។

Υπηρεσίες Διαερμηνείας

Παρέχουμε βοήθεια για την κατανόηση των διαδικασιών διαχείρισης του Προγράμματος σε άτομα τα οποία μιλούν τα Αγγλικά ως δεύτερη γλώσσα. Αν χρειάζεστε βοήθεια, παρακαλείστε να τηλεφωνήσετε στην Pioneer στο Τηλέφωνο (413) 539-9900 ή (800) 423-4586 και ζητήστε τον Αντιπρόσωπο Εξυπηρέτησης Πελατών για διαερμηνεία. Ο διαερμηνείας (που δεν είναι υπάλληλος της Pioneer) θα σας βοηθήσει στην απάντηση των ερωτήσεών σας.

خدمات الترجمة الفورية

إننا نقدم المساعدة في فهم الإجراءات الإدارية للحظة، للأشخاص الذين تكون اللغة الإنجليزية لغة ثانية لديهم. إذا احتجت للمساعدة، من فضلك اتصل بـ "Pioneer" على رقم ٥٣٩-٩٩٠٠ (٤١٣) أو ٤٢٣-٤٥٨٦ (٨٠٠)، واطلب من "ممثل خدمة العملاء" الذي بخدمتك توفير مترجم فوري لك. وسوف يساعدك هذا المترجم الفوري (وهو ليس موظفًا لدى "Pioneer") في الحصول على إجابة لأسئلتك.

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WHAT YOU SHOULD KNOW ABOUT OBTAINING BENEFITS

IDENTIFICATION CARD (ID CARD): In order to obtain benefits under this Plan, you must present an identification card. Identification cards for medical benefits, including prescription drug coverage are issued by Pioneer Management Systems, Inc.

THE PROVIDER NETWORK: One of the many benefits of selecting a PPO health insurance option is access to a network of preferred providers. You have access to the Health Care Value Management (“HCVM”) network and Pioneer Network. When you obtain services from a provider who participates in your designated PPO network, the claim will be processed at the in network benefit level.

The PPO networks include physicians, hospitals, ambulatory care centers, chiropractors, podiatrists, physical therapists, speech therapists, occupational therapists, mental health professionals, laboratories, imaging centers, freestanding surgical centers, home care agencies, hospice services providers, and other health care providers.

Centers of Excellence are an important adjunct to the PPO network. A referral from Pioneer is required to access one of these facilities, so please call Pioneer’s Utilization Management Department if you or our physician think that you would be best served at a *Center of Excellence*.

THE PROVIDER DIRECTORY: Your Educational Institution will have a copy of the Provider Directory. You can also find a searchable copy of your designated Provider Directory online. The Pioneer Directory can be found on Pioneer’s website at www.pioneerhealth.com The HCVM Provider Directory can be found on their website at www.hcvm.com. If you wish to confirm whether a provider participates in your designated PPO network, you may also call Pioneer’s Customer Service Department at (413) 539-9900 or (800) 423-4586.

SELF-REFERRAL TO A SPECIALIST: The Plan allows you to see a specialist without obtaining a referral (except that a referral is required to access the Plan’s *Centers of Excellence* and behavioral health facilities.) You may, however, be best served by contacting your general practitioner, family practitioner, obstetrician/gynecologist, internist, pediatrician, or other primary care provider (“PCP”) for advise before seeking specialty care.

YOUR IN-NETWORK BENEFITS: The Plan encourages you to obtain care from providers who participate in the PPO network. By selecting a participating provider, you minimize out-of-pocket expenses.

YOUR OUT-OF-NETWORK BENEFITS: You always have the option of obtaining care from non-participating providers. Your out-of-pocket expenses are generally higher when you obtain care from an out-of-network provider. Your out-of-network deductible and coinsurance obligations are shown on the Schedule of Benefits. Out-of-Network benefits are payable at a percentage of the provider’s fee, up to the Usual, Customary and Reasonable charge.

EMERGENCY CARE: You may obtain health care services for Emergency Medical Conditions:

- 1) You or someone acting on your behalf, may call the local pre-hospital emergency medical system directly by dialing 911 or its local equivalent when confronted by a situation that a prudent layperson would consider an Emergency Medical Condition.
- 2) We do not discourage you from using the local pre-hospital emergency medical service system, the 911-telephone number, or the local equivalent;
- 3) You will not be denied coverage for medical and transportation expenses incurred as a result of any such Emergency Medical Condition; and
- 4) Prior authorization is not required for Emergency Medical Conditions (including post-stabilization services.)

If you need to receive service for an Emergency Medical Condition and cannot reasonably reach a provider that participates in the Pioneer network, payment for medical care related to the emergency is made at the same level as if you had been treated by a participating provider.

The Plan's definition of an Emergency Medical Condition means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- 1) placing the health of the insured or another person in serious jeopardy;
- 2) serious impairment of bodily function; or
- 3) serious dysfunction of any bodily organ or part; or
- 4) with respect to a pregnant woman who is having contractions -
 - a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - b) that transfer may pose a threat to the health or safety of the woman or unborn child.

CONTINUED TREATMENT WITH NON-PARTICIPATING PROVIDERS: Continued treatment with non-participating providers (i.e., providers who are not in the designated network) is allowed in the following situations:

- 1) If you are in your second or third trimester of pregnancy, and the health care provider who is treating you in connection with your pregnancy is involuntarily disenrolled (for other than quality-related reasons or for fraud), you may continue treatment with the provider, consistent with the terms of the *Policy*, for the period up to and including your first postpartum visit. This continued treatment provision is conditional, as explained below.
- 2) If you are terminally ill and the health care provider who is treating you in connection with your terminal illness is involuntarily disenrolled (for other than quality-related reasons or for fraud), you may continue treatment with the provider, consistent with the terms of the *Policy* until your death. This continued treatment provision is conditional, as explained below.
- 3) If you are a new insured under this Policy, and your College only offers you a choice of carriers in which your physician is not a participating provider, and your physician is providing you with an ongoing course of treatment or is your primary care physician, We will provide coverage for health services provided by such physician who is not a participating provider for up to thirty (30) days from the effective date of your coverage. If you are in the second or third trimester of pregnancy, this provision applies to services rendered through your first postpartum visit. If you have a terminal illness, this provision applies to services rendered until death. This continued treatment provision applies if the services are not excluded under this Policy as Preexisting, and is conditional, as explained below.

In order for treatment to be continued as indicated above, the provider must be willing:

- 1) to accept reimbursement at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to you in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled;
- 2) to adhere to Our quality assurance standards and to provide us with necessary medical information related to the care provided; and
- 3) to adhere to Our policies and procedures regarding prior authorization, and providing services pursuant to a treatment plan. With regard to a provider that has not been disenrolled, he or she must agree to these same provisions and accept reimbursement at Our current reimbursement rate. Benefits that would not have been covered if the provider involved was a preferred provider, will not be covered.

COVERAGE FOR PEDIATRIC SPECIALTY CARE: Your Policy provides coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics.

FILING A CLAIM: When you receive services from a PPO provider, they will file a claim for payment. You are not required to pay the preferred provider in advance, and preferred providers are contractually

prohibited from “balance billing” for covered services. The provider will, however, collect applicable copayments and bill for deductible and coinsurance obligations, if any, that you may have under the Plan.

When you receive services from out-of-network providers, you may have to pay the provider and send your claim to Pioneer for reimbursement. The Plan will reimburse you for covered services, less any deductible or coinsurance amounts and any special copayments or penalties. Claims must be submitted to Pioneer within ninety (90) days of the service. You may obtain claim forms from your school or from Pioneer. The claim form must be accompanied by an itemized bill and proof of payment.

OTHER INFORMATION ABOUT YOUR PLAN

COVERED BENEFITS: The following is a general summary of covered benefits that you are entitled to receive on a nondiscriminatory basis: The Plan covers Medically Necessary services, treatments and supplies that are for the treatment of an injury or illness, as well as certain preventive services, as specifically detailed in the Plan. Covered services include charges for hospital inpatient, outpatient, and emergency room services, ambulatory care centers, surgical care facilities, rehabilitation facilities, residential treatment facilities, behavioral health facilities, physician visits, medical equipment and supplies, ambulance charges, diagnostic lab and imaging charges, behavioral health services, hospice benefits, home health care benefits, maternity services, physical and manipulative therapy, speech therapy, and occupational therapy, as well as any other benefits required by state law. The Plan includes certain Exclusions and Limitations, which are clearly described in the Policy.

PRESCRIPTION DRUGS: This Plan includes a Prescription Drug Benefit, which covers most legend drugs prescribed by a Physician, and certain pharmaceutical supplies. Some drugs may not be covered. Quality of Life enhancing agents that may improve your appearance or quality of life, but are not Medically Necessary are not covered. Drugs that are considered Experimental or Investigational are not covered. You will receive a list of prescriptions that are excluded and/or require prior authorization with your enrollment materials. This list is subject to change from time-to-time. Any applicable copayment and/or deductible for your Plan as well as the coverage percentage and benefit maximum is shown on the Schedule of Benefits. (If you have a prescription filled at a non-participating retail pharmacy (e.g., a pharmacy that does not participate in the Pharmacy Network), reimbursement will be made subject to the plan's out-of-network deductible and coinsurance provisions.) Please contact Pioneer at (800) 423-4586 if you have questions about the Prescription Drug Benefit.

CRITERIA FOR DISENROLLMENT OR DENIED ENROLLMENT: Your coverage may be canceled, or non-renewed, only in the following circumstances:

- 1) Your failure (or the failure of the responsible party) to make payments required under the contract;
- 2) Your misrepresentation or fraud;
- 3) Your commission of acts of physical or verbal abuse which pose a threat to providers or other insureds which are unrelated to your physical or mental condition, provided that the Commissioner of Insurance prescribes or approves the procedures for the implementation of the provisions of this clause;
- 4) Non-renewal or cancellation of the Blanket contract through which you receive coverage.

OBTAINING GRIEVANCE REPORT: We are required to file with the Office of Patient Protection a report, detailing, for the previous calendar year, the total number of:

- a) filed grievance, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution, and
- b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.

You may obtain the above information directly from the Office of Patient Protection, 250 Washington Street, 2nd floor, Boston, MA, 02108. You may also contact them by telephone at (800) 436-7757, via facsimile at (617) 624-5046 or via their Internet site at www.state.ma.us/dph/bhqm.

SUMMARY DESCRIPTION OF QUALITY ASSURANCE PROGRAM: Pioneer's quality assurance programs are conducted under the supervision of the Medical Director, with policies set by the Quality Assurance Committee. We have developed a comprehensive and integrated quality assurance program to ensure that cost considerations do not dictate a course of action harmful to the patient. The focus of our quality improvement program includes:

- 1) health promotion;
- 2) membership and credentials;
- 3) reference to quality standards in provider agreements;

- 4) ongoing peer review and related instructional programs;
- 5) practice pattern analysis;
- 6) prompt investigation and resolution of any and all grievances;
- 7) periodic, random surveys to ascertain attitudes toward quality; and
- 8) regular review of the composition of the provider network.

PROCEDURE FOR MAKING DECISIONS ABOUT THE EXPERIMENTAL OR INVESTIGATIONAL NATURE OF DRUGS, DEVICES OR TREATMENTS IN CLINICAL TRIALS:

The following procedures are generally followed when Pioneer's clinical staff makes decisions about the experimental or investigational nature of drugs, medical devices, or treatments, which are in clinical trials:

- 1) Conduct a search of the medical literature, specifically articles appearing in peer-reviewed journals;
- 2) Determine whether the proposed treatment is medically necessary, and whether other traditional treatments have been tried without success;
- 3) Review the results of the clinical trials conducted thus far;
- 4) Obtain any supporting documentation from the patient's physician;
- 5) Obtain independent expert review, upon the request of the Medical Director;
- 6) The Medical Director makes a determination whether the drug, medical device or treatment in clinical trials should be covered, or denied as experimental or investigational.

PROCESS FOR ESTABLISHING CLINICAL GUIDELINES

AND UTILIZATION REVIEW CRITERIA: Physicians, and other health care providers are utilized as a resource for establishing and reviewing policies for clinical decision making.

PHYSICIAN PROFILING INFORMATION: You should know that so-called physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts. They are located at 10 West Street, 3rd floor, Boston, MA 02111.

INFORMATION AVAILABLE FROM THE OFFICE OF PATIENT PROTECTION: You should know that certain information is available from the Office of Patient Protection, a division within the Department of Public Health, and that you may contact that Office for assistance in understanding your managed care rights. The Office of Patient Protection is authorized to assist consumers with questions about managed care, develop Internet programs and otherwise communicate information about managed care, monitor quality-related health plan information, and develop recommendations regarding ways to improve the quality of managed care plans. The information available includes the Plan's: Certificate of Insurance, and amendments; provider directory; required disclosure information; physician termination report; premium revenue expended for health care services; grievance report for the previous calendar year; and any other information required to be provided by Us to the Office of Patient Protection. You may write to the Office of Patient Protection, 250 Washington Street, 2nd floor, Boston, MA 02108 or you may contact them by telephone at (800) 436-7757, via facsimile at (617) 624-5046 or via their internet site at www.state.ma.us/dph/bhqm.

ENROLLMENT AND TERMINATION

WHO IS ELIGIBLE? All undergraduate students taking 3/4 or full-time credit hours or more are automatically enrolled in this Plan, 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.

WHO IS AN ELIGIBLE DEPENDENT?

- 1) Your unmarried Child/Children (including any stepchild, adopted child or any child who has been placed for adoption with the Insured) up to age nineteen (19) who are not self-supporting. (Newborn children, including newborn infants of a dependent and adopted children, are covered automatically for the first thirty-one (31) days following birth.) To continue coverage beyond this period, you must apply in writing for Dependent coverage within thirty-one (31) days of birth;
- 2) Your unmarried Child/Children over the age limit who are incapable of self-sustaining employment due to a documented physical handicap or mental retardation, who are chiefly dependent upon you for support and maintenance. Proof of incapacity must be provided within thirty-one (31) days of the date he or she would normally lose coverage. We may periodically ask for proof of continued incapacity;
- 3) Your lawful Spouse, who resides with you.

Members of any armed forces or any person who has permanent residence outside of the U.S.A. are not eligible. If an insured enters the armed forces, We will refund the unearned pro rata premium to the insured.

Children born to Dependents who are not subject to adoption or guardianship proceedings are not eligible for coverage, unless they are living with the Insured Employee.

EFFECTIVE DATE OF COVERAGE/ POLICY TERM: This Policy is effective on the date shown on the Validation of Coverage (located on the cover of this Certificate of Insurance) and expires on the Expiration date shown on the Validation of Coverage. An eligible student's coverage becomes effective on that date or the date the application and full premium are received by Us. If you lose other coverage that you had on the effective date of this Policy and you request coverage under this Plan within thirty (30) days of losing such coverage, you will be covered on the date of the application and payment of premium.

WHEN IS MY COVERAGE EFFECTIVE FOR PRE-EXISTING CONDITIONS? Pre-Existing Conditions as defined below are excluded from coverage under this Plan for six (6) months from the Enrollment Date, unless otherwise indicated on the Schedule of Benefits. This provision shall not apply to individuals who have been insured under the school's policy for at least six (6) consecutive months or under a previous qualifying health plan, provided such coverage was in force within thirty (30) days prior to the effective date of this Policy.

The term "Pre-Existing Condition" means conditions which have, during the six (6) months immediately preceding the effective date of coverage, manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received or a pregnancy existing on the effective date of coverage.

TERMINATION OF COVERAGE: The insurance for any Insured shall terminate on the earliest of the following dates:

- 1) The date the Policy terminates; or
- 2) The Premium due date if the College fails to pay the required premium for the Insured, except as the result of an inadvertent error.

CONTINUATION COVERAGE

CONTINUATION OF MEDICAL COVERAGE UNDER STATE LAW: If the Insured becomes ineligible or leaves the school group for any reason, coverage will continue for 31 days unless, during the thirty-one (31) days, the Insured becomes entitled to similar benefits elsewhere.

EXTENSION OF BENEFITS: If an Insured is confined to a hospital on the day his or her insurance terminates, expenses incurred after such termination date and during the continuation of that hospital confinement shall be payable in accordance with this Plan, but only while they are incurred during the ninety (90) day period following such termination of insurance. The total payments per Insured Person will not exceed the Aggregate Maximum under this Plan.

DESCRIPTION OF COVERED BENEFITS:

COVERED SERVICES

Please see the “Schedule of Benefits” section (located at the end of this book) for plan maximums, copayments and/or applicable deductibles and coinsurance and other important benefit information.

STUDENT ACCIDENT AND SICKNESS INSURANCE PROVISIONS CONCERNING ACCIDENT AND SICKNESS EXPENSE BENEFITS

When an Insured has a Loss from Sickness or Accident which is covered by the Basic Sickness and Accident Expense Benefit provisions and limited as shown on the Schedule, We will pay the Expense incurred within the Benefit Period. Our payment will not be more than the Aggregate Maximum for all Loss from a single Sickness or Accident, as shown on the schedule.

BASIC ACCIDENT AND SICKNESS EXPENSE BENEFIT PROVISIONS CONCERNING HOSPITAL EXPENSE

A- Hospital Room and Board (R&B) Expense:

When an Insured's Sickness or Accident requires Hospital Confinement, We will pay the Hospital Room and Board Expense not to exceed the semi-private rate. Such payment is subject to the Maximum Per Day and the Maximum Number of days, if any, as shown on the schedule.

B- Hospital Miscellaneous Expense:

We will pay Expenses incurred by an Insured during a Hospital Confinement or as an Outpatient for day surgery for services provided by a Hospital, Ambulatory Surgical Center or Ambulatory Medical Center, as shown on the schedule.

We will pay for:

- a) anesthesia;
- b) operating room;
- c) laboratory tests;
- d) x-rays;
- e) physiotherapy services;
- f) drugs;
- g) medicines
- h) dressings;
- i) other necessary non-room and board Expenses; and
- j) pre-admission testing

BASIC ACCIDENT AND SICKNESS EXPENSE BENEFIT PROVISIONS CONCERNING SURGICAL EXPENSE

- a) When an Insured's Sickness or Accident requires surgery, We will pay the Expense, subject to the Maximum Surgical Benefit. Only one surgical procedure will be covered when multiple procedures are performed through the same incision unless medically necessary.
- b) If the surgery requires the services of an anesthetist, who is not employed or retained by the Hospital in which the operation is performed, We will pay the Loss incurred.

- c) If the surgery requires the services of an Assistant Surgeon, We will pay the Loss incurred.

All maximums are shown on the schedule.

**BASIC ACCIDENT AND SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING IN-HOSPITAL PHYSICIAN'S FEES EXPENSE**

When an Insured's Sickness or Accident requires the services of a Physician, We will pay the Expense for such services subject to:

- a) the Insured being confined to a Hospital;
- b) the Sickness or Accident is one for which benefits are payable under Hospital Expense;
- c) the Maximum Per Day (limited to one visit per day); and
- d) the Maximum Number of Days, if any.

All maximums are shown on the schedule.

**BASIC ACCIDENT AND SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING AMBULANCE EXPENSE**

When an Insured's Sickness or Accident requires the use of an ambulance, We will pay the Expense up to the Maximum. All maximums are shown in the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING VOLUNTARY TERMINATION OF PREGNANCY**

We will pay the Expense for the voluntary termination of an Insured's Pregnancy. This benefit is paid in lieu of all other benefits. All maximums are shown in the schedule.

**BASIC ACCIDENT AND SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING HOSPITAL OUTPATIENT EXPENSE**

If an Insured's Sickness or Accident require the use of Outpatient facilities of an Ambulatory Surgical Center, Ambulatory Medical Center, Hospital or Physician's office for:

- a) the use of diagnostic x-ray;
- a) laboratory services,
- b) an emergency room or operating room;
- c) physician visits;
- d) second surgical opinion
- e) consultation visits;
- f) physiotherapy;
- h) radiation therapy;
- i) chemotherapy;
- j) dental accident expense;
- k) DME (Orthopedic braces and appliances); and
- l) Allergy testing

under a Physician's direction, We will pay the Expense. All maximums are shown in the schedule

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING SICKNESS DENTAL EXPENSE**

If the Insured's Sickness requires treatment for impacted wisdom teeth, We will pay as follows:

- a) the Expense up to the Hospital maximum if confined to a Hospital; or
- b) the Expense up to the Outpatient Maximum if not confined to a Hospital.

All maximums are shown in the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING MENTAL ILLNESS, CHEMICAL DEPENDENCY
AND ALCOHOLISM EXPENSE**

When an Insured requires treatment for chemical dependency We shall pay the Expense subject to the following:

A) Benefits for Hospital Confinement

Benefits for Expenses arising as an Inpatient for treatment of alcoholism or chemical dependency in a licensed facility including those especially for detoxification or rehabilitation of intoxicated persons or alcoholics, or chemical dependents, and which is licensed by the Department of Public Health for those services, or in a residential alcohol or chemical dependency treatment program, shall be no different than those for any other Sickness up to thirty (30) days in any calendar year. Notwithstanding the foregoing provisions, the period of confinement may be calculated by substituting, solely at our option and, where medically appropriate, two days of outpatient day treatment for one day of inpatient hospital care. For the purposes of this section, an "outpatient hospital day" shall be defined by the division of insurance.

B) Benefits for Outpatient Services

When not so confined as in A above, We will pay the Expense up to a maximum of \$500 in any one policy year. Our payment will not exceed the Benefit per Visit. Benefits start with the first visit after the Deductible Number of Visits is satisfied.

For the treatment of alcoholism or chemical dependency, covered services are those furnished by (1) an accredited or licensed hospital, or by (2) any public or private facility or portion thereof providing services especially for the detoxification of intoxicated persons or alcoholics or chemical dependents and which is licensed by the Department of Public Health for those purposes. Consultants or treatment sessions furnished by a facility in this clause shall be rendered by a physician or psychotherapist fully licensed under the provisions of chapter 112 who devotes a substantial portion of his time treating intoxicated persons or alcoholics or chemical dependents. For the purposes of this clause "psychotherapist" shall mean a person fully licensed to practice medicine under the provision of said chapter 112 and who devotes a substantial portion of this time to the practice of psychiatry.

The limitation on benefits for the treatment of alcoholism or chemical dependency established by subdivision (H) of section 110 shall not apply when said treatment is rendered in conjunction with treatment for mental disorders.

MENTAL ILLNESS EXPENSE

When an Insured requires treatment for mental illness, excluding chemical dependency, We shall pay the Expense on a nondiscriminatory basis 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 section 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, and (10) any biologically based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the Department of Mental Health in consultation with the commissioner of the division of insurance.

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.

Benefits for children and adolescents 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 interaction of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care physician, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but limited to : (1) an inability to attend school as a result of such a disorder, (2) the need to hospitalize the child or adolescent as a result of such a disorder, or (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

This Policy does not contain any separate annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of the mental health benefits described above. Medically necessary benefits for the diagnosis and treatment of all other mental disorders not otherwise provided for in this section and which are described in the most recent edition of DSM during each 12 month period for a minimum of 60 days of inpatient treatment and for a minimum of 24 outpatient visits. All maximums are shown on the schedule.

Benefits shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary, active, and noncustodial treatment for said mental disorders to take place 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 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.

Psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit.

“Licensed mental health professional” shall mean a licensed 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.

“DSM” means the Diagnostic and Statistical Manual of the American Psychiatric Association.

**BASIC [ACCIDENT AND SICKNESS EXPENES BENEFIT PROVIVIONS
CONCERNING PRE-ADMISSION TESTS EXPENSE**

Regardless of any other Policy limitation, We will pay the Hospital Expense for the use of Outpatient facilities as needed for tests before an Insured is admitted for surgery, provided that:

- a) tests are required for diagnosis and treatment of the ailment for which surgery will be done;
- b) a Hospital bed and operating room have been reserved before the tests are made;
- c) the surgery is done within seven (7) days after the tests; and
- d) the Insured is physically present for tests.

Our payment will not exceed the amount, which would be due if the Insured were an inpatient. All maximums are shown in the schedule.

BASIC ACCIDENT AND SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING EMERGENCY MEDICAL EXPENSE

We will pay the Emergency Medical services Expenses of a Hospital if an Insured is covered for inpatient Hospital Expenses. Emergency Medical condition is defined as a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function or serious dysfunction of a body organ or part, or with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 U. S. C. section 1395dd (e)(1)(B). Such coverage must extend to the point at which an insured has been stabilized for discharge or transfer, following such stabilization.

Prior authorization is not required for Emergency Medical conditions (including post-stabilization services).

All maximums are shown in the schedule.

BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING MATERNITY INPATIENT CARE AND HOME VISITS

We will provide benefits for Expenses incurred in connection with:

Inpatient Hospitalization services for a mother and a newborn child for a minimum of forty eight (48) hours after an uncomplicated vaginal delivery and ninety-six (96) hours after delivery by an uncomplicated cesarean section.

Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital We shall pay expenses for the cost of additional hospitalization for the newborn for up to four (4) days.

If a mother requests a shorter length of stay than that provided in this section, (if the mother decides in consultation with her attending provider, that less time is needed for recovery), one (1) home visit within 24 hours after hospital discharge, and one (1) additional visit if prescribed by the attending physician will be provided subject to the Outpatient Physician Expense Benefit

- 1) Any home visit shall be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;
- 2) Any home visits shall be provided by a registered nurse, licensed physician, or certified nurse midwife.

All maximums are shown in the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISION
CONCERNING MAMMOGRAPHY AND PAP SMEAR EXPENSE**

We shall pay the Expense for Low-Dose Mammography Screening for breast cancer screening or diagnosis, or for any nonsymptomatic woman covered under the Policy subject to the following:

- 1) A baseline mammogram for ages thirty-five to forty;
- 2) A mammogram for ages forty and older, inclusive, every year or more frequently based on the recommendation of the patient's physician;

We shall pay the Expense for annual pelvic examinations and Pap smear examinations for women age 18 and older; including FDA approved cytological screening technology.

The Expense will be reimbursed the same as any other radiological/lab examination covered by the Policy.

"Low-Dose Mammography Screening" means the X-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the X-ray tube, filter, compression device, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other Physician for reading, interpreting or diagnosing based on such X-ray.

All maximums are shown in the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING INFERTILITY TREATMENT EXPENSE BENEFIT**

We will provide benefits for all Outpatient Expenses for all non-experimental infertility procedures including, but not limited to:

- a) Medically necessary expenses of diagnosis and treatment of infertility to persons residing within the Commonwealth of Massachusetts;
- b) Artificial insemination (AI);
- c) In Vitro Fertilization and Embryo Placement (IVF-EP);
- d) Gamete Intra Fallopian Transfer (GIFT);
- e) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any;
- f) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility;
- g) Zygote Intrafallopian Transfer (ZIFT)

Please note:

- a) Benefits for infertility related drugs are payable on the same basis as any other prescription drugs.
- b) Infertility is defined as a condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year.
- c) Experimental or investigational infertility procedures, surrogacy or reversal of voluntary sterilization are not covered.
- d) Pre-Existing Condition limitations do not apply to these benefits.
- e) Long-term sperm or egg preservation, or long-term cryopreservation not associated with active infertility treatment is not covered.
- f) Infertility treatment needed as a result of prior sterilization or sterilization reversal is not covered.

All maximums are shown in the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING CLINICAL TRIALS**

We shall provide benefits for Expenses incurred in connection with qualified clinical trials for patient care services.

“Patient care services” means a health care item or service that is furnished to an insured 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.

All maximums are shown in the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING CHILD EARLY INTERVENTION SERVICES EXPENSE**

If dependent coverage is provided under the policy, We will provide benefits for Expenses for covered dependents incurred in connection with Early Intervention Services:

1. Medically necessary speech and language therapy
2. Medically necessary occupational therapy
3. Medically necessary physical therapy
4. Nursing Care
5. Psychological counseling

The above services apply for covered dependents from birth until their third birthday.

This benefit is limited to a maximum of \$5,200 per year per child and aggregate benefit of \$15,600 over the total enrollment period.

Coverage for medically early intervention services shall be subject to such dollar limits, deductibles and coinsurance the same as any other sickness.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING LEAD POISONING SCREENING**

We will provide benefits for expenses incurred in connection with:

- a) blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and family services.

All maximums are shown on the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING DIABETES EQUIPMENT, SUPPLIES, TRAINING**

We will provide benefits for expenses incurred in connection with:

Coverage for expenses for all medically appropriate and necessary diabetes equipment, diabetes supplies, therapeutic/molded shoes and shoe inserts and diabetes outpatient self-management training and educational services, including medical nutrition therapy, that the insured's treating physician or other appropriately licensed health care provider, or a physician who specializes in the treatment of diabetes, certifies are necessary for the treatment of:

- 1) insulin-using diabetes
- 2) noninsulin-using diabetes;

- 3) elevated blood glucose levels induced by pregnancy; or
- 4) gestational diabetes

All maximums are shown on the schedule.

BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING BONE MARROW TRANSPLANTS

We will provide benefits for the Expenses arising from bone marrow transplants for:

- A) Persons who have been diagnosed with breast cancer that has progressed to metastatic disease; Provided, however, that person shall meet the criteria established by the department of public health. The department of public health shall promulgate rules and regulations establishing criteria for eligibility for coverage hereunder, which shall be consistent with medical research protocols reviewed and approved by the National Cancer Institute.

“Metastatic Disease” means Stage III and Stage IV breast cancer, as well as Stage II breast cancer which has spread to ten or more lymph nodes, as defined by the American College of Surgeons.

“Bone marrow Transplant” means use of high dose chemotherapy and radiation in conjunction with transplantation of autologous bone marrow or peripheral blood stem cells, which originate in the bone marrow.

All maximums are shown on the schedule.

BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING CHILD PREVENTIVE, PRIMARY CARE EXPENSE

We shall pay the Expense for preventive, and primary care services for covered children.

“Preventive and Primary Care” shall mean services rendered to a covered dependent child of an insured from the date of birth through the attainment of six years of age. Preventive and Primary Care shall 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. Such services 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.

All maximums are shown on the schedule.

BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING HOSPICE CARE EXPENSE

We shall pay the Expense for hospice care for persons who are determined to be terminally ill with a limited life expectancy of less than six (6) months.

These services are to be provided by, or arranged to be provided through an interdisciplinary team, which shall include health care and counseling providers, in a home setting, on an outpatient basis, and on a back-up inpatient basis, not to exclude those patients requiring only inpatient care.

Such services shall include, but not be limited to, physician’s services, nursing care provided by or under the supervision of a registered professional nurse, social services, volunteer services and counseling services provided by professional or volunteer staff under professional supervision.

This benefit will be provided to the extent as any other Sickness.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING SCALP HAIR PROSTHESIS EXPENSE**

We shall pay the Expense for Scalp Hair Prosthesis worn for hair loss suffered due to the treatment of any form of cancer or leukemia provided that the coverage is subject to a written statement by the treating physician that the scalp hair prosthesis is medically necessary.

Coverage pursuant to the law shall not exceed \$350 per year.

All maximums are shown on the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING SPEECH, HEARING AND LANGUAGE DISORDERS**

We will provide benefits for expenses incurred in connection with the medically necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists. Such services must be rendered within the lawful scope of practice for such speech-language pathologists or audiologists regardless of whether the services are provided in a hospital, clinic, or private office. Such coverage shall not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting.

All maximums are shown on the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING CARDIAC REHABILITATION EXPENSE**

Coverage is hereby provided for cardiac rehabilitation on the same basis as any other Sickness. Treatment must be initiated within 26 weeks after the diagnosis of such disease. Cardiac rehabilitation means multi-disciplinary, medically necessary treatment of persons with documented cardiovascular disease.

All maximums are shown on the schedule.

**BASIC SICKNESS EXPENSE BENEFIT PROVISIONS
CONCERNING LEUKOCYTE TESTING EXPENSE**

Coverage is hereby provided for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. The coverage shall cover 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.

All maximums are shown on the schedule.

**BASIC ACCIDENT AND SICKNESS EXPENSE BENEFITS PROVISIONS
CONCERNING OUTPATIENT PRESCRIBED MEDICINES, ENTERAL
FORMULAS AND CANCER DRUGS EXPENSE**

When an Insured's Sickness or Accident requires Prescribed Medicines, we will pay the Expense as shown on the schedule.

We will cover:

Nonprescription enteral formulas for home use, for which a physician has issued a written order and which are 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.

We will also cover food products modified to be low protein for inherited diseases of amino and organic acids.

We will also include prescription drugs considered "off label" (a drug that has not been approved by the United States Food and Drug Administration) if the Health Resources Commission determines that the drug is recognized effective for the treatment of that indication.

In publications that the commissioner determines to be equivalent to:

- A) The American Hospital Formulary Service drug information
- B) "Drug Facts and Comparisons" (Lippincott-Raven Publishers)
- C) The United States Pharmacopoeia drug information; or
- D) Other publications that have been identified by the United States Secretary of Health and Human Services as authoritative;
 - 1) In the majority of relevant peer-reviewed medical literature
 - 2) By the United States Secretary of Health and Human Services

Required coverage of a prescription drug under this shall include coverage for medically necessary services associated with the administration of the drug to be contraindicated.

"Off-label" use means a prescription drug used in the treatment of cancer, and HIV/aids which has been approved by the United States Food and Drug Administration and such drug is used for indication other than those approved by said Food and Drug Administration.

All Maximums are shown on the Schedule.

BASIC SICKNESS EXPENSE BENEFIT CONCERNING CONTRACEPTIVE DRUGS, DEVICES AND HORMONE REPLACEMENT THERAPY

When an Insured's Expense is for hormone replacement therapy for peri and postmenopausal women and any prescribed drug or device that is FDA approved as a contraceptive, or for outpatient services such as consultations, examinations, procedures and medical services related to contraceptive methods, we will pay the Expense in accordance with the applicable coverage Deductible, and Maximum shown in Section 1-Schedule of Insurance.

All Maximums are shown on the Schedule.

STATE MANDATED BENEFITS

This Blanket Policy conforms to any and all coverage mandates imposed by the Commonwealth of Massachusetts upon Blanket accident and sickness plans. Benefits described are payable only for services and supplies which are medically necessary and appropriate, required for treatment of an illness, injury, or condition and are recommended and approved by an attending Physician or other provider practicing within the scope of his/her license.

POLICY LIMITATIONS AND EXCLUSIONS

LIMITATIONS APPLICABLE TO ALL MEDICAL CARE BENEFITS FOR YOU AND YOUR DEPENDENTS.

This policy does not cover Loss nor provide benefits for:

- 1) Expenses for dental treatment including temporomandibular joint dysfunction (TMJ), except for treatment resulting from Injury to natural teeth; or as specifically provided by a Sickness Dental Expense Benefit, if included in this Policy;
- 2) Services normally provided without charge by your health service, infirmary or hospital, or your school's employees;
- 3) Routine eye exams and contacts; replacing eyeglasses or prescription therefor; routine examinations and services related to hearing examinations or hearing aids (except for hearing screenings required by law for infants); or treatment for hearing defects not related to an Injury or Sickness;
- 4) Routine physical examinations and preventive care, except as required by law and specifically provided for by this policy; elective surgery and elective treatment; services solely to improve appearance, for personal hygiene; services specifically for dietary control, custodial, sanitarial or rest care;
- 5) Cosmetic surgery. Cosmetic surgery does not include reconstructive surgery which results from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or deformity of a Dependent child. Cosmetic surgery due to congenital defects will be covered for Newborn Children;
- 6) Treatment or supplies for the Newborn Infant except that required for the treatment of a covered Accident or Sickness and as required by law and specifically provided for by this Policy;
- 7) Voluntary termination of pregnancy except as specifically provided;
- 8) Skydiving, recreational 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;
- 9) Injury or Sickness resulting from any declared or undeclared war;
- 10) Injury due to participation in a riot; commission of or attempt to commit a felony;
- 11) Injury or Sickness while in the armed forces of any country. When an Insured enters such armed forces, We will refund the unearned pro rate premium to the Insured;
- 12) Injury or Sickness covered by any workers' compensation or occupational disease law;
- 13) Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges;
- 14) Expenses in excess of \$2,000 while (a) participating in any interscholastic club, intercollegiate or professional sport, contest, or competition; (b) traveling to or from such sport, contest or competition as a participant; (c) while participating in any practice or conditioning program for such sport, contest or competition;
- 15) Pre-existing Conditions, in excess if \$2,500 for a six month period preceding the effective date of this Policy;
- 16) Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
- 17) Expenses covered by any other valid and collectible medical health or accident insurance.
- 18) Braces, appliances and supplies except as specifically provided for by this Policy;
- 21) Topical acne treatment; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; blood plasma; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a hospital or rest home;
- 22) Organ Transplants.

COORDINATION OF BENEFITS

This Policy coordinates with other plans under which an individual is covered so that the total benefits available will not exceed 100% of the allowable expenses.

When a claim is made, other valid and collectible insurance pays its benefits without regard to this Policy. This Policy then adjusts benefits so that the total benefits available will not exceed the allowable Expenses. No plan pays more than it would without the coordination provision. In the absence of other valid and collectible insurance, it is our intention that Expenses incurred in connection with any covered Injury or Sickness shall be fully payable subject to the terms, conditions and limitations of this Policy.

“Other valid and collectible insurance” shall mean any plan providing medical expense benefits for or by reason of dental Physician, nurse, Hospital care, treatment, or confinement, or the performance of surgery and/or anesthesia, which benefits are provided by (1) any type of service plan contracts, any group or blanket insurance, employee benefit plan or any plan arranged through an employer, trustee, union, or employee benefit association; or (2) any plan or program created or administered by national or state government, or agencies thereof; or (3) individual insurance. We will not limit or exclude payment on a claim because the Insured is eligible for or is provided medical assistance under the provisions of Title XIX of the Social Security Act.

A plan without a coordination provision is always the primary plan.

CLAIMS PROCEDURES

HOW TO SUBMIT A CLAIM: Pioneer Management Systems, Inc. (Pioneer) is the company responsible for claims processing and performing utilization management on behalf of **Markel Insurance Company**. Claim forms are to be submitted directly to Pioneer at this address:

Pioneer Management Systems, Inc.

330 Whitney Avenue
P.O. Box 6600
Holyoke, MA 01041-6600
(413) 539-9900 or (800) 423-4586

You may obtain claim forms from your School or from Pioneer. If you use a network provider, you do not have to submit a claim form. If your provider is submitting a claim for which you have assigned benefits, he or she may use any standard or generally accepted claim form. The claim form must be complete and accompanied by an itemized bill that shows specific services, dates of service, and other information in detail. We must receive written proof of loss (i.e., a completed claim form) within ninety (90) days of the date of service.

PAYMENT AND ASSIGNMENT OF BENEFITS: For in-network benefits, payments will be made directly to the provider. For out-of-network expenses, all benefits are payable to you, unless assigned. You may assign benefits to a duly authorized medical provider. In that case, benefits are payable directly to the provider. Any such payment discharges our responsibility to pay such claims. In cases where the non-custodial parent is providing coverage, and the custodial parent submits a claim, payment may be made directly to the custodial parent.

Payment may be made directly to an agency administering Title XIX or IV-D of the Social Security Act or a contractor who has contracted with the state to provide Medicaid services, when services are rendered on

behalf of a Dependent child. We must be advised when the claim is filed that benefits are to be paid directly to the agency.

Claims are adjudicated within forty-five (45) days of receipt by Pioneer. If benefits are payable, payment will be made within this forty-five (45) day period or you will be notified that special circumstances exist that will delay the processing of your claim.

If you do not understand a claim payment, or if you are dissatisfied with the denial of a claim or the amount paid, you should contact Pioneer.

RIGHTS AND RESPONSIBILITIES

INQUIRY AND GRIEVANCE PROCESS

Inquiry: The Inquiry process is an informal process during which We attempt to answer questions and/or resolve concerns communicated to us on your behalf, within three (3) business days. If We fail to answer your question or resolve your concern, then you may have the Inquiry processed as an internal Grievance. The Inquiry process may not, however, be used for review of an adverse determination (involving medical necessity determinations), which should be resolved as an internal Grievance.

Inquiry Procedure:

- 1) If you have an Inquiry (e.g., a question or concern which has not been the subject of an adverse determination), you should call Pioneer and speak with a Customer Service Representative. You may reach customer service at Pioneer by calling: (413) 539-9900 or (800) 423-4586. We will attempt to resolve your inquiry to your satisfaction within three (3) business days of the Inquiry.
- 2) If We are unable to explain your Inquiry or resolve your concern to your satisfaction, you may, at your option, have the Inquiry processed as an internal Grievance.

1st level Internal Grievance: If you wish to file a Grievance concerning any aspect or action of your health plan, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations, or if your Inquiry was not resolved to your satisfaction, you may request an internal Grievance. Your duly authorized representative or health care provider may request a Grievance on your behalf, in regard to a specific matter, with proper authorization.

1st level Internal Grievance Procedure:

- 1) You may initiate a 1st level Grievance in a variety of ways. A Grievance may be initiated by telephone, in person, by mail, or by electronic means.
 - a) If you wish to initiate a Grievance by telephone, you should call Pioneer at (413) 539-9900 or (800) 423-4586 and ask to speak with a Patient Advocate.
 - b) If you wish to initiate a Grievance in person, you may do so by scheduling an appointment with a Patient Advocate. You should call Pioneer at (413) 539-9900 or (800) 423-4586 to schedule a convenient time to meet with a Patient Advocate at our corporate offices, which are located at 330 Whitney Avenue, Holyoke, MA.
 - c) If you wish to initiate a Grievance by mail, it should be mailed to: Patient Advocate, Pioneer Management Systems, Inc., P.O. Box 6600, Holyoke, MA 01041-6600.
 - d) If you wish to initiate a Grievance by electronic means, you may send an E-mail to Patientadvocate@Pioneerhealth.com. We cannot, however, assure the confidentiality of clinical information sent via electronic means.
- 2) We will reduce your oral Grievance to writing and forward a copy of it to you within forty-eight (48) hours of receipt or provide you with written acknowledgment of your written Grievance within fifteen (15) business days of receipt.
- 3) We will issue a written determination of your Grievance within twenty (20) business days of receipt of the Grievance, and a signed release, if necessary, to obtain pertinent medical records. Our Grievance determination will be sent to you in writing. It will include substantive clinical justification for the decision.
- 4) You will receive an expedited resolution to your Grievance in the following situations: (a) If you are hospital confined, your Grievance will be resolved before you are discharged from the hospital; (b) If you have been denied services or durable medical equipment ("DME"), your physician may invoke the option for an automatic reversal of the decision denying coverage,

pending the outcome of the Grievance process, within forty-eight (48) hours (or earlier for DME) of receipt of certification by your physician that: the service or DME at issue in a Grievance is medically necessary; the denial of coverage would create a substantial risk of serious harm to the patient; and that the risk of serious harm is so immediate that the provision of such service or DME should not await the outcome of the normal Grievance process. If your physician exercises the option of automatic reversal earlier than forty-eight (48) hours for DME, then he or she must further certify as to the specific, immediate and severe harm that will result to the patient absent action within the forty-eight (48) hour time period; (c) If you are terminally ill and have submitted a Grievance, it shall be resolved within five (5) business days from the receipt of the Grievance. If the expedited review affirms denial of coverage or treatment, you (or your duly authorized representative) will receive within five (5) business days of the decision a statement from Us setting forth the specific medical and scientific reasons for denying coverage or treatment and a description of alternative treatment, services or supplies covered or provided, if any. In addition, you (or your duly authorized representative) may request a conference. The conference will be scheduled within ten (10) days (or within five (5) business days of the request, if the treating physician determines that the effectiveness of either the proposed or alternative treatment would be materially reduced if not provided at the earliest possible date.) You, your authorized representative, or both may attend the conference.

2nd level Internal Grievance (Optional): If you are not satisfied with the 1st level Grievance determination, you (or your duly authorized representative) may request a 2nd level internal Grievance. A 2nd level internal Grievance must be requested within 45 days of receipt of the 1st level Grievance determination.

2nd level Internal Grievance (Optional):

- 1) You may initiate a 2nd level Grievance by contacting your Patient Advocate by telephone, in person, by mail, or by electronic means by following the same process to initiate a 1st level Grievance, as explained above.
- 2) We will reduce your oral Grievance to writing and forward a copy of it to you within forty-eight (48) hours of receipt, or provide you with written acknowledgment of a written Grievance within forty-eight (48) hours of receipt.
- 3) We will issue a written determination of your Grievance within ten (10) business days of receipt of the request for a 2nd level Grievance, provided that We have a signed release, if necessary, to obtain medical records. The determination will include substantive clinical justification for the decision.
- 4) You will receive an expedited resolution to your 2nd level Grievance for the same situations that require an expedited resolution for a 1st level Grievance. The expedited 2nd level Grievance will be resolved within forty-eight (48) hours.
- 5) You (or your duly authorized representative) may appear before the committee or communicate with the committee by conference call or other means).

Other information regarding the Internal Grievance Process:

- 1) Any 1st level Grievance not properly acted upon within thirty (30) business days or the time limits established for an Expedited Review shall be deemed resolved in favor of the insured. Time limits include any extensions made by mutual written agreement. You will be asked to sign a form extending this thirty-(30) day period in order to proceed with the 2nd level internal Grievance process.
- 2) Grievances will be reviewed by an individual or individuals who are knowledgeable about the matters at issue in the grievance.
- 3) Grievances of adverse determinations will be reviewed with the participation of an individual(s) who did not participate in any of the prior decisions on the Grievance. In at least one level of review of grievances of adverse determinations, these individuals shall be actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure or provide the treatment which is the subject of the Grievance.
- 4) When a grievance requires review of medical records, the thirty (30) business day period will not begin to run until the insured submits a signed authorization for release of medical records. With

regard to a Grievance that follows an Inquiry, the thirty (30) day time period begins on the day immediately following the three (3) business day period for processing an Inquiry (if the grievance does not require the review of medical records), or on the day the insured notifies Us that he or she is not satisfied with the response to the Inquiry.

- 5) We may issue a resolution within thirty (30) business days if We are not provided with the signed authorization, or have not received the necessary clinical information. You may request reconsideration of the Grievance when the clinical information is received late, or has not been received, but is expected to become available within a reasonable time period. We may reconsider the Grievance, at our option. If We approve your reconsideration request, We will establish a new period for review, which shall not exceed thirty (30) business days.
- 6) If a Grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect through completion of the internal Grievance process (except for medical care which was terminated pursuant to a specific time or episode-related exclusion.)
- 7) In the case of a Grievance which involves an adverse determination, the written resolution will include a substantive clinical justification that is consistent with accepted principles of professional medical practice, and will 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, if any; (4) reference and include applicable clinical practice guidelines and review criteria; and (5) notify the insured of the procedures for requesting external review.
- 8) You may contact the Office of Patient Protection, 250 Washington Street, 2nd floor, Boston, MA 02109 or you may contact them by telephone at (800) 436-7757, via facsimile at (617) 624-5046 or via their internet site at www.state.ma.us/dph/bhqm for assistance with an internal Grievance.

External Review: If you are not satisfied with the 2nd level Grievance determination or you decided not to pursue the 2nd level internal Grievance process, you or your duly authorized representative may request an External Review.

External Review Procedure:

- 1) You may request an External Review by filing a request in writing with the Office of Patient Protection ("OPP"). This must be done within forty-five (45) days of receipt of written notice of the final Grievance determination. You will be required to pay a fee of twenty-five dollars (\$25) to the OPP, which shall accompany your request for an external review. This fee may be waived by the OPP if it determines it will cause an extreme financial hardship.
- 2) You may also request an expedited External Review by including a certification, in writing, from your physician, that delay will pose a serious and immediate threat to your health.
- 3) You may apply to the External Review panel to seek the continuation of coverage for terminated services during the period the review is pending. The review panel may order the continuation of coverage or treatment when it determines that substantial harm to the insured's health may result absent such continuation or for other good cause, as the review panel shall determine.
- 4) You may write to the Office of Patient Protection, 250 Washington Street, 2nd floor, Boston, MA 02108 or you may contact them by telephone at (800) 436-7757, via facsimile at (617) 624-5046 or via their internet site at www.state.ma.us/dph/bhqm.
- 5) Decisions of the External Review panel are binding.

RIGHT TO DISCUSS ALL TREATMENT OPTIONS WITH YOUR PROVIDERS: You have the right to ask questions and discuss all treatment options with your providers. In fact, We encourage you to do so.

ACCESS TO AND CONFIDENTIALITY OF MEDICAL RECORDS: You agree that We may have access to all medical records and related information (except if prohibited by law) which is necessary for Us to make determinations and administer your benefits under this Policy. We may require consent to the disclosure of information regarding services for mental disorders only to the same or similar extent in which We require consent for the disclosure of information for other disorders. If you refuse or fail to sign

any releases which We present to you, the claim in question may be denied. We may collect information from past, present or future health care providers and other insurance companies. We may disclose this information to necessary persons and entities for the purpose of administering your benefits (e.g., making claim determinations, enrollment eligibility verification, coordination of benefits, subrogation, and reinsurance and/or ceding activities; performing case management and quality assurance activities; conducting utilization management; grievance and claims reviews; audit and other related activities), and when required by law. You have the right to review information that We obtain. Except for these types of purposes, medical information will be kept confidential and will not be disclosed without your consent.

DEFINITIONS

Accident means a sudden, unexpected and unintended identifiable event caused solely by an external physical force resulting in Injury to a Person. Accident does not include a loss arising out of health condition or health impairment.

Ambulatory Surgical Center or Ambulatory Medical Center means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician's office.

Benefit Period means the time during which an Insured Person's incurred Expense for a covered Injury or Sickness is eligible for reimbursement. The Benefit Period selected starts on the date of the accident for an Injury or the date of the first treatment for a Sickness.

Complications of Pregnancy means conditions, whose diagnosis are distinct from pregnancy, but are adversely affected by or are caused by pregnancy. Such complications include, but are not limited to: a) acute nephritis; b) nephrosis; c) cardiac decompensation; d) missed abortion; e) hyperemesis gravidarum; f) preeclampsia; and g) similar medical and surgical conditions of comparable severity. Complications of Pregnancy also includes: a) nonelective Cesarean section; b) ectopic pregnancy which is terminated; and c) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy shall not mean: a) false labor; b) occasional spotting; c) Physician prescribed rest during the period of pregnancy; d) morning sickness; or e) similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct Complication of Pregnancy.

Consultant means a Physician, usually a Specialist, called in to see a patient by another Physician.

Copayment means that portion of eligible Expenses which is payable by the Insured. Copayments do not apply toward Deductible and coinsurance obligations.

Covered Medical Expenses means Usual and Customary Expense for Medically Necessary services, supplies or treatment which are: 1) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 2) made for services and supplies included in the Schedule of Benefits; and 3) in excess of the amount stated as a Deductible, if any.

Deductible means the amount an Insured is required to pay as provided by the applicable coverage under this Policy in the event of a Loss.

Dependent means:

- a) a spouse living with the Insured;
- b) any unmarried child of the Insured (including any stepchild, adopted child, or child who has been placed for adoption with the Insured) under the age of nineteen (19) years who is not self-supporting.

Expense means the Usual and Customary charges for Medically Necessary treatment, service or supplies. Such Expense shall not include any amount not customarily charged to persons without insurance.

Extension of Benefits means that if an Insured Person is confined to a hospital on the day his or her insurance terminates, expenses incurred after such termination date and during the continuance of that hospital confinement shall be payable in accordance with this Plan, but only while they are incurred during the 90 day period following such termination of insurance. The total payments per Insured Person will not exceed the Aggregate Maximum under this Plan.

Home Health Care Expense means the care and treatment of an Insured who is under the care of a Physician, only if hospitalization or confinement in a skilled nursing facility as defined in title XVIII of the

Social Security Act would otherwise have been required if home care was not provided, and the plan covering the Home Health Service is established and approved in writing by such Physician. Home Care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to public health law.

Hospital means a licensed institution including a tax supported institution of the state, which has on the premises, or prearranged access to, medical and surgical facilities. It must maintain permanent facilities for the care of overnight resident patients under the care of a Physician. It must have a Registered Nurse (R.N.) always on duty or call. Confinement in the special wing of a Hospital used primarily as a nursing, rest, convalescent or extended care facility is not confinement in a hospital, unless such confinement is because of a lack of space in the hospital's full service wing.

Hospital Confined and Hospital Confinement means a stay in a Hospital for 18 or more consecutive hours as an admitted bed patient by reason of Injury or Sickness for which benefits are payable.

Injury means bodily harm caused by an accident which occurs while this Policy is in force and is the sole cause of the Loss.

Insured means an eligible student or an eligible student's Dependent covered by this Policy.

Loss means medical Expense caused by Injury or Sickness and covered by this Policy.

Medically Necessary means healthcare services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the Insured in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

Natural Teeth means teeth, the major portion of the individual tooth is present, regardless of fillings, and is not abscessed or defective.

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

The Insured has the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within 31 days after the child's birth: 1) give us written notice of birth, and 2) pay the required additional premium 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.

If the Insured is supporting a 19-year-old Dependent child because of mental retardation or physical handicap, coverage may be continued. We must receive written notice and proof of such conditions within 31 days of the child's 19th birthday. Thereafter, We may require such proof once each year.

Outpatient means care an Insured receives for a Covered Medical Expense under this Policy for a Sickness or Injury while not Hospital confined.

Period of Sickness means the time required for diagnosis and treatment for a Sickness or related complications resulting in a Loss.

Physician means a licensed doctor of medicine (MD), doctor of osteopathy (DO), chiropractor (DC), podiatrist (DPM), dentist (DDS or DMD), optometrist (OD), psychologist (PhD), licensed independent

clinical social worker (LICSW), licensed nurse mental health clinical specialist, licensed mental health counselor and any other licensed practitioner including a nurse practitioner, physician assistant, nurse midwife, or nurse anesthetist who is required to be reimbursed by state law. A Physician must be acting within the scope of their license. This definition does not include someone who is related to you by blood, marriage, or adoption or who is normally a member of your household.

Physiotherapy means any form of the following: physical or mechanical therapy; diathermy; ultrasonic therapy; heat treatment in any form; manipulation; subluxation or massage administered by a Physician.

Pre-existing Condition means: 1) conditions which had, during the 6 months immediately preceding the effective date of coverage, manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received; or 2) a pregnancy existing on the Effective Date of coverage for which care or treatment was received before the Effective Date.

Prescription Medicines or Drugs means any medicine or drug, under applicable state law, that is dispensed only with a written prescription from a Physician and has a label bearing the legend: "Caution: Federal law prohibits the dispensing without a prescription." It is also any mixed medicine with at least one ingredient bearing the above legend.

Sickness means disease or illness which causes a Loss while the insured is covered by this Policy. "Sickness" includes Normal Pregnancy and Complications of Pregnancy.

Specialist means a Physician who limits his practice to the study and treatment of one class of diseases or who confines his interest to specific organs or systems within the body.

Usual and Customary Expense means an Expense which: a) is charged for treatment, supplies or medical services Medically Necessary to treat the Insured's condition; and b) does not exceed the usual level of charges made for similar treatment, supplies or medical services in the locality where the Expense is incurred.

We, us or ours means Markel Insurance Company.

You, your or yours means the Policyholder (school, college, university or institution of learning).

GENERAL PROVISIONS

EFFECTIVE DATE OF INDIVIDUAL INSURANCE

Each Insured applying for coverage on or before the Policy's Effective Date shall be insured on the Effective Date. Any Insured who applies for coverage after the Effective Date, will be covered on the date of the application and full payment of premium are received by us.

If the Insured loses other coverage that they had on the effective date of the policy and they request coverage within 30 days of losing such coverage, they will be covered on the date of the application and payment of premium.

Within 20 days after the Insured's coverage is effective, you must provide us written notice of the Insured's name, the date coverage became effective, and the premium paid. If you fail to comply, the Insured shall not have coverage unless and until you comply.

The insurance for any Insured shall terminate on the earliest of the following dates:

1. the date this Policy is terminated; or
2. the Premium due date if you fail to pay the required premium for the Insured, except as the result of an error.

ENTIRE CONTRACT; CHANGES

This Policy, your attached application and the Insureds' application are the entire contract. Any change, modification or waiver of this Policy or a certificate issued under it must be in writing and signed by one of the following: our President; our Vice President; a Secretary; or Assistant Secretary. We are not bound by any promises or representations made by an agent or other person except as stated above.

INCONTESTABILITY

Any statement in applications by you or an Insured will, in the absence of fraud, be deemed representations and not warranties. Only statements in an application by you or an Insured will be used to void this Policy or defend against a claim. However, such statements cannot be used to void coverage or defend a claim of an Insured unless a copy of the application with this statement was given to the Insured.

Except for non-payment of premium, We cannot contest this Policy after it has been in effect for 2 years from the Effective Date. After this insurance has been in force for 2 years during an Insured's lifetime, no statement made by that Insured about his or her insurability will be used to contest the validity of this coverage.

GRACE PERIOD

This Policy has a 31-day Grace Period. If the premium is not paid by the due date, it may be paid during the 31 days immediately following the due date. This Policy will remain in force during the Grace Period. The Grace Period does not apply:

- a) to the first premium due; or
- b) to premiums due thereafter if We have given you 60 days prior notice that We will not renew this Policy.

FILING A CLAIM

When you receive services from a PPO provider, they will file a claim for payment. You are not required to pay the preferred provider in advance, and preferred providers are contractually prohibited from "balance billing" for covered services. The provider will, however, collect applicable copayments and bill for deductible and coinsurance obligations, if any, that you may have under the Plan.

When you receive services from out-of-network providers, you may have to pay the provider and send your claim to us or our administrator for reimbursement. The Plan will reimburse you for covered services, less any deductible or coinsurance amounts and any special copayments or penalties. Claims must be submitted to us or our administrator within ninety (90) days of the service. You may obtain claim forms from your school or form us or our administrator. The claim form must be accompanied by an itemized bill and proof of payment.

TIME PAYMENT OF CLAIMS

After receiving written Proof of Loss, We will immediately pay all benefits as they accrue.

PAYMENT OF CLAIMS

After receiving a claim, We will pay all benefits to the Insured, if living, or at the Insured's request, to the Hospital or person rendering services.

Benefits for accidental death, if any, will be paid to the named beneficiary, if then living. If no beneficiary is named, or the named beneficiary predeceases the Insured, such benefits will be paid to the Insured's estate.

PHYSICAL EXAMINATION

We, at our expense, have the right to have any Insured examined by a Physician of our choice as often as necessary while a claim is pending.

LEGAL ACTIONS

No legal action may be brought to recover on this Policy: a) within 60 days after written Proof of Loss has been given as required; or b) after 6 years from the time written Proof of Loss is required, or after the expiration of the applicable statute of limitations, if greater.

CHANGE OF BENEFICIARY

The Insured can change the beneficiary at any time giving us written notice. The beneficiary's consent is not required for this or any other change in coverage.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of such statutes.

ASSIGNMENT

This Policy and an Insured's coverage may not be assigned.

RECORDS MAINTAINED

You must maintain adequate records of this insurance.

EXAMINATION AND AUDIT

At any reasonable time and for any purpose relating to this Policy, your records shall be open for our inspection and audit. Such examination may be made during the Policy Term; within 3 years after this Policy is terminated; or until final settlement of all claims hereunder, whichever is later.

SUBROGATION

When benefits are paid to or for an Insured Person under the terms of this Policy, We shall be subrogated, once the Insured had been indemnified for his Loss, unless otherwise prohibited by the law, to the rights of recovery of such Insured Persons against any person who might be acknowledged liable or found legally liable by a Court of competent jurisdiction for the Injury or Sickness that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by us of the benefits We have paid for such hospitalization and treatment, and We shall pay fees and costs associated with such recovery.

RIGHT OF RECOVERY

Payments made by us which exceed the Covered Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder, shall be recoverable by us from or among any persons, firms, or corporations to or for whom such payments were made.

WORKERS' COMPENSATION

This Policy is not in place of and does not affect any requirement for such coverage by workers' compensation insurance.

MARKEL INSURANCE COMPANY

(A Stock Insurance Company, Herein Called the Company)

AGREES with the Policyholder, named below in consideration of the payment of the premium and subject to the limits of liability, exclusions, conditions and other terms of this policy.

TO PAY the benefits described in item 4, Coverage Provisions.

Policy Number 04200348

SECTION 1

SCHEDULE

1. Name of Policyholder: Endicott College
376 Hale Street
Beverly, MA 01915

2. Policy Period: From 8/19/04 To 8/19/05 , 12:01 A.M. Standard Time at the address in item 1.

3. Coverage: This Policy provides insurance with respect to such and so many of the following Insurance Provisions as set forth below for the Benefit Amount set opposite thereto. The insurance with respect to this Schedule of Insurance shall be applicable to the Class of Insured Persons specified in Item 3 Schedule.

Schedule of Medical Expense benefits				
The Plan provides benefits for the charges incurred by an Insured Person for loss due to a Covered Accident or Sickness up to a \$ 25,000 aggregate maximum unless otherwise stated. Benefits will be paid for each service as scheduled below.				
INPATIENT BENEFITS	Participating Preferred Provider	Copay/ Deductible	Out of Network (non-participating provider)	Copay/ Deductible
Hospital Room and Board	90% Preferred Allowance		80% U&C	
Maximum:	See Aggregate		See Aggregate	
Hospital Miscellaneous Expense	90% Preferred Allowance		80% U&C	
Maximum:	See Aggregate		See Aggregate	
Surgeon Expense:	90% Preferred Allowance		80% U&C	
Maximum:	\$5,000		\$5,000	
Assistant Surgeon Expense	30% Preferred Allowance		30% U&C	
Maximum:	Incl in Surgeon Expense		Incl in Surgeon Expense	
Anesthetist Expense	30% Preferred Allowance		30% U&C	
Maximum:	Incl in Surgeon Expense		Incl in Surgeon Expense	
Physician Expense	90% Preferred Allowance		80% U&C	
Maximum:	See Aggregate		See Aggregate	
Pre-Admission Testing Expense	Paid under Hospital Miscellaneous Expense		Paid under Hospital Miscellaneous Expense	
Maximum:				
OUTPATIENT BENEFITS	Participating Preferred Provider	Copay/ Deductible	Out of Network (non-participating provider)	Copay/ Deductible
Surgeon Expense	80% Preferred Allowance		80% U&C	
Maximum:	\$5,000		\$5,000	
Assistant Surgeon Expense	90% Preferred Allowance		70% U&C	
Maximum:	\$1,500		\$1,500	
Anesthetist Expense	90% Preferred Allowance		70% U&C	
Maximum:	\$1,500		\$1,500	

OUTPATIENT BENEFITS	Participating Preferred Provider	Copay/ Deductible	Out of Network (non-participating provider)	Copay/ Deductible
Second Surgical Opinion Expense Maximum:	See Outpatient Expense		See Outpatient Expense	
Day Surgery Miscellaneous Expense (outpatient Hospital Services for surgery)	90% Preferred Allowance \$2,000		80% U&C \$2,000	
Emergency Room Expense Maximum:	See Outpatient Expense		See Outpatient Expense	
Physiotherapy Expense Maximum:	See Outpatient Expense		See Outpatient Expense	
High Cost Procedures Maximum:	80% U&C \$2,000	\$200	80% U&C \$2,000	\$200
Outpatient Expense : Physician Visits Consultation Visits Second Surgical Opinion Physiotherapy (one per day) Emergency Room Diagnostic x-ray and lab Radiation Chemotherapy Chiropractor Hospital Outpatient Dept. Maximum:	100% Preferred Allowance 100% Preferred Allowance 100% Preferred Allowance 90% Preferred Allowance 90% Preferred Allowance 90% Preferred Allowance 90% Preferred Allowance 90% Preferred Allowance NIL 90% Preferred Allowance \$2,500	\$10 \$10 \$10 \$10 \$50 (waived if admitted) \$35 \$35 \$35 N/A \$35	80% U&C 80% U&C 80% U&C 80% U&C 80% U&C 80% U&C 80% U&C 80% U&C NIL 80% U&C \$1,500	\$10 \$10 \$10 \$10 \$50 (waived if admitted) \$35 \$35 \$35 N/A \$35
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS	Participating Preferred Provider	Copay/ Deductible	Out of Network (non-participating provider)	Copay/ Deductible
Inpatient Mental Health Expense Maximum:	60 day maximum annually Same as any other Sickness See Aggregate		60 day maximum annually Same as any other Sickness See Aggregate	
Outpatient Mental Health Expense Maximum:	24 visit maximum annually 100% Preferred Allowance See Aggregate	\$10	24 visit maximum annually 80% U&C See Aggregate	\$10
Inpatient Substance Abuse Expense Maximum:	30 day maximum annually Same as any other Sickness See Aggregate		30 day maximum annually Same as any other Sickness See Aggregate	
Outpatient Substance Abuse Expense Maximum:	80% Preferred Allowance \$500		80% U&C \$500	
Inpatient and Outpatient State Mandated Mental Health Expense for Biologically Based Mental Disorders & Rape Related Mental or Emotional Disorders Maximum:	Same as any other Sickness See Aggregate		Same as any other Sickness See Aggregate	

ADDITIONAL BENEFITS	Participating Preferred Provider	Copay/ Deductible	Out of Network (non-participating provider)	Copay/ Deductible
Medication Management Expense Benefit Maximum:	Included in Outpatient Expense		Included in Outpatient Expense	
Prescription Drug Expense Maximum:	Included in Outpatient Expense	\$5 Generic \$15 Brand Name	NIL	N/A
Cytologic Screening Expense (pap smear) Maximum:	100% U&C		100% U&C	
Mammography Examination Expense Maximum:	100% U&C		100% U&C	
Maternity Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Ambulance Expense Maximum:	100% U&C \$150		100% U&C \$150	
Dental Sickness Expense Maximum:	NIL		NIL	
Dental Accident Expense Maximum:	80% U&C \$500 per tooth		80% U&C \$500 per tooth	
Durable Medical Equipment Expense, braces (non-replacement) and non-dental prosthetic devices Maximum:	100% U&C \$100		100% U&C \$100	
Intercollegiate Sports Expense Maximum:	As any other Injury \$2,000		As any other Injury \$2,000	
Club Sports Expense Maximum:	NIL		NIL	
Voluntary Termination of Pregnancy Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Basic Accident Expense (non scheduled) Maximum:	NIL		NIL	
Allergy Testing or Treatment Expense: Maximum:	80% U&C \$225		80% U&C \$225	
Attention Deficit Disorder Expense Maximum:	NIL		NIL	
Bone Marrow Transplant Expense Maximum:	Covered as any other Sickness		Covered as any other Sickness	

ADDITIONAL BENEFITS	Participating Preferred Provider	Copay/ Deductible	Out of Network (non-participating provider)	Copay/ Deductible
Breast Reconstructive Surgery Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Cardiac Rehabilitation Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Child Early Intervention Services Expense Maximum:	\$5,200		\$5,200	
Child Preventive & Primary Care Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Diabetes Equipment,, Supplies, Training Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Home Care Services Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Hospice Care Services Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Infertility Treatment Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Lead Poisoning Screening Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Leukocyte Testing Expense Maximum:	Same as any other Sickness		Same as any other Sickness	
Scalp Hair Prosthesis Expense Maximum:	\$350		\$350	
Speech, Hearing & Language Disorder Expense Maximum:	Same as any other Sickness		Same as any other Sickness	

4. Coverage Provisions:

Student Health Services Referral required Yes No Pre-Admission Certification Required Yes No
Term of Coverage: 52 Week Benefit Period 104 Week Benefit Period Extension of Benefits
Other Insurance: Excess/Coordination of Benefits Primary/Motor Vehicle Excess Primary

5. Amendatory Endorsement(s) executed simultaneously herewith:

In Witness whereof, the Company has caused this policy to be signed by its President and a Secretary, but it shall not be binding upon the Company unless countersigned by a licensed resident agent of the Company.