

# 2007 – 2008

Especially designed for the students of

**MOUNT HOLYOKE.**  
College

## **Student Medical Insurance Plan**

Policy Number CUH201393  
South Hadley, Massachusetts

**MAKE SURE YOU'RE ADEQUATELY COVERED.**

Massachusetts State Law requires that your insurance be equivalent to or better than the State's minimum standards, and it is your responsibility to make this determination. Mount Holyoke College's Student Health Insurance Plan exceeds minimum standards and is designed to meet Mount Holyoke College students' needs. This Plan will function as your primary coverage except in the event that you are also covered as an employee under an employer group medical plan.

**BEFORE YOU WAIVE COVERAGE** under the Mount Holyoke College Student Health Insurance Plan, check your current coverage carefully as frequently students arrive on campus without adequate coverage, especially if covered by a Health Maintenance Organization (HMO) or a managed care plan that has limited or no benefits in the Five College area. Make sure you're fully covered while on campus and throughout the policy year for inpatient and outpatient hospitalization, diagnostic testing and x-ray services, prescription drugs, mental health services, and that your current plan doesn't have high deductibles.

Many of the services offered by the Mount Holyoke College Health Center will not be covered by your insurance. Situations where this frequently arise are for laboratory testing, x-rays, outpatient mental health visits and physical therapy services. Employer groups are increasingly ending dependent coverage at age 19. Students who declare financial independence to gain eligibility for financial aid programs are also not eligible as a dependent for coverage under a parent's health insurance policy, regardless of the student's age.

Insured Students can have more than one coverage. The Mount Holyoke College Student Health Insurance Plan is primary leaving other insurance, if available, to cover copayments or uninsured expenses in excess of the Student Health Insurance Plan. Many students choose this option for convenience and security.

**MOUNT HOLYOKE COLLEGE  
STUDENT HEALTH PLAN**

August 15, 2007 - August 14, 2008

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## **THE MOUNT HOLYOKE COLLEGE STUDENT HEALTH INSURANCE PLAN**

The Mount Holyoke College Student Health Insurance Plan is a comprehensive, managed care program specifically designed for most college-age women's health needs. The Student Health Plan consists of two parts: Prepaid On-Campus Health Care and a Student Health Insurance Plan. The Student Health Insurance Plan provides coverage when the College is not in session or when the student is referred to non-College medical services by the Health Center. Students who waive the Student Health Insurance Plan may still purchase the Prepaid On-Campus Health Care Option.

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## **STUDENT ELIGIBILITY AND ENROLLMENT**

All regular, full-time and fellow students are eligible to enroll in the Student Health Plan. Frances Perkins Program students, graduate students, or special students carrying two or more courses for academic credit and Graduate Assistants are also eligible. Only students officially enrolled as students at the Mount Holyoke College campus or enrolled (and receiving Mount Holyoke College academic credit) under a College-sponsored off-campus program are eligible to participate. Frances Perkins Program students who are regular employees of the College are not eligible.

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## **ONLINE STUDENT ENROLLMENT MANAGEMENT PROCESS**

The Student Health Plan combines the coverage available through the Student Health Insurance Plan and the Optional Prepaid On-Campus Health Care. Eligible students have three (3) options: 1) participate in the Student Health Plan which includes the Optional Prepaid On-Campus Health Care), 2) participate in the Prepaid On-Campus Health Care (waiving the Student Health Insurance Plan), or 3) waive participation in both plans and maintain their current private insurance only.

Students who are currently enrolled in a health insurance plan of comparable coverage that will be in effect until August 15, 2008 can waive the Student Health Insurance Plan. Recognizing that health insurance coverage may change and as required by state law, students will be asked to provide proof of comparable coverage in order to waive the Student Health Insurance Plan at the beginning of each academic year.

### **Waiver Deadline**

The deadline for students to complete the Online Enrollment/Waiver Form is August 5, 2007 for annual coverage and February 10, 2008 for students newly

enrolled for the Spring Semester. Students who waive the Student Health Insurance Plan in the fall waive coverage for the entire policy year. The Online Enrollment/Waiver process is the only accepted process for making your insurance selection. **Students who do not submit the Online Enrollment/Waiver Form by the deadline will remain enrolled in and billed for the Student Health Insurance Plan.**

### **Enrollment/Waiver Process**

To enroll or waive the insurance, go to [www.kosterweb.com](http://www.kosterweb.com), click on “Student Access” and select Mount Holyoke College from the dropdown box. First Time Users will need to create a new User Account (User Name and Password), first and last name, student ID number, date of birth and email address. Students returning to the site should log in under “Returning Students” with their existing User Account information. After creating or accessing a User Account, log in, select “Student Waive/Enroll Forms” and then select the “2007-2008 Mount Holyoke College Annual Enrollment/Waiver Form”. To complete the Waiver option of the online form, you will need to provide information about your current health insurance plan: name, claims address and toll-free customer service telephone number of the insurance carrier, the name of the policyholder and policyholder ID or group number. The purpose of collecting this information is for waiving the student insurance plan only and is not used for any other purpose. The Online process is the only accepted process for waiving coverage.

Immediately upon submitting the Online Form, you will receive a confirmation number that the Online Form has been submitted. Print this confirmation number for your records, as it is your proof that the Online Form was submitted. If you do not receive a confirmation number, you will need to correct any errors and resubmit the Online Form.

Mount Holyoke College reserves the right to reject a waiver request when the insurance carrier or claims administrator is not a domestic or U.S. based company. **International students may not waive the Student Health Insurance Plan unless they are covered by an insurance carrier based in the United States (embassy-sponsored programs are no longer considered comparable coverage).**

In the event students waive the Student Health Insurance Plan coverage and then lose current coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break

in coverage. For petitions received after the 31 days, the effective date of coverage will be the date that the petition is received at Koster Insurance. If approved, the premium will not be prorated.

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## **DEPENDENT ELIGIBILITY AND ENROLLMENT**

Students enrolled in the Student Health Insurance Plan may enroll their eligible Dependents as defined with an additional cost. “Dependent” means: (a) the Insured Student’s spouse or same-sex domestic partner residing with the Insured Student; or (b) the Insured Student’s unmarried children under the age of twenty-six years; or (c) unmarried children of the Insured Student’s Dependent child, provided such children are under the age of twenty-six years. Same-sex domestic partners will be required to complete and notarize a Domestic Partner Affidavit and complete a Dependent Enrollment Form. Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child, for dependent benefits from and after the moment of birth, or any child placed with the Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption. To continue the child’s dependent benefits past the first 31 days, or to obtain any other dependent coverage, the Insured Student must complete and return the Dependent Enrollment Form with payment directly to Student Financial Services within 31 days of the child’s birth, or date of placement for adoption, or date of marriage.

The term “children” includes an Insured Student’s biological children; step-children; and adopted children from the date of placement in the Insured Student’s home. It also includes an Insured Student’s newborn dependent children who, as of the last day of the 30-day period beginning with the date of birth, are covered under Creditable Coverage; or an Insured Student’s adopted dependent children under the age of 18, who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, are covered under Creditable Coverage (except this shall not apply to coverage the adopted child may have had before such adoption or placement.)

A child’s coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or earn his or her own living as a

result of physical handicap or mental retardation; (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance. Within 31 days after the child reaches the age limit, the Insured Student must send Us proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age. Any dependent on active duty in any military, naval or air force of any country is not eligible for coverage under this Policy.

Dependents who are regular employees of Mount Holyoke College are not eligible. A Dependent cannot be insured under this Plan if the Insured Student loses eligibility under the Student Health Insurance Plan.

### **Dependent Enrollment**

Payment for Dependent coverage is in addition to the fee for your individual student coverage. New or previously insured Dependents must be enrolled by September 15, 2007 for annual coverage or by February 15, 2008 for spring semester for new students to Mount Holyoke College. If the deadline for enrolling an eligible dependent is not met, the dependent cannot be added until the following school term. The deadline to add eligible dependents due to a qualifying event (i.e. birth, marriage, loss of coverage) is 31 days from the qualifying event in order to avoid a break in continuous coverage. If the qualifying event deadline is not met, the effective date will be the date the Dependent Enrollment Form is returned to Student Financial Services. An Insured Person who has a break in continuous coverage will not be covered for Pre-existing Conditions that originated before or during such break except as otherwise may be provided for. Students interested in enrolling their eligible Dependents should contact Student Financial Services.

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## **PLAN COSTS AND PERIOD OF COVERAGE**

	<b>Annual</b> 8/15/07 to 8/14/08	<b>Fall Semester</b> 8/15/07 to 1/14/08	<b>Spring Semester</b> 1/15/08 to 8/14/08
Student	\$1,730.00	\$ 745.00	\$ 985.00
Spouse	\$4,165.00	\$1,755.00	\$2,410.00
Child(ren)	\$3,095.00	\$1,304.00	\$1,791.00

\*Rates include an Administrative Fee

## **Prepaid On-Campus Health Care Only**

**(Only available to students when College is in session).**

	<b>Academic Annual</b> 8/15/07 - 5/31/08	<b>Fall Semester</b> 8/15/07 - 1/14/08	<b>Spring Semester</b> 1/15/08- 8/14/08
Student	\$200.00	\$100.00	\$100.00

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### **POLICY TERM**

The Mount Holyoke College Student Health Insurance Plan is effective at 12:01 a.m. on August 15, 2007. An eligible student's coverage becomes effective on that date or the date the application and full premium are received by the College or Koster Insurance Agency, whichever date is later. The Annual Policy terminates at 12:01 a.m. on August 15, 2008 or at the end of the period, through which the premiums are paid, whichever is earlier. Students may enroll for the Fall Semester only, which is August 15, 2007 to January 15, 2008.

The insurance for the Spring Semester is effective at 12:01 a.m. on January 15, 2008 or the date the application and full premium are received by the College or Koster Insurance Agency, whichever date is later and terminates at 12:01 a.m. on August 15, 2008.

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### **PREMIUM REFUND POLICY**

Except for a withdrawal due to an Injury or Sickness, any Insured Student withdrawing from the school during the first 31 days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of the premium will be made. Insured Students withdrawing after 31 days will remain covered under the Plan for the full period for which the premium has been paid. Students taking a leave or graduating from the college at the end of the fall term may request a refund of premium by submitting a written request to cancel Spring Coverage from Student Financial Services within 30 days from the end of the fall term. Students who cancel coverage for the Spring and who return to the college the subsequent Fall and who re-enroll in the Student Health Insurance Plan, will experience a break in coverage and will be subjected to the Pre-Existing Condition Limitation. Premiums received by the Company are fully earned upon receipt and are non-refundable except as specifically provided. Coverage for an Insured Student entering the Armed Forces of any country will terminate as of the date of such entry. Those Insured Students withdrawing from

the school to enter military service will be entitled to pro-rata refund of premium upon written request.

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## **EYEMED VISION CARE**

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network consists of over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, JC Penney Optical, Target Optical, and Pearle Vision. You will receive a separate EyeMed ID card. It is important to understand the EyeMed Vision Care Program is not insurance. There is no waiting period; you can take advantage of the savings through EyeMed immediately upon receipt of your EyeMed ID card. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% to 45% off regular retail pricing. In addition, you can receive discounts from 5% to 15% off laser correction surgery at some of the nation's most highly qualified laser correction surgeons and also discounts on routine eye exams. To locate a participating provider, you can call 1-866-8EYEMED or go online at [www.enrollwitheyemed.com](http://www.enrollwitheyemed.com). This plan is not underwritten by Combined Insurance Company of America.

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## **DENTAL SAVINGS AND WELLNESS SUPPORT PROGRAMS**

The cost of dental care is a major concern to both students and health service administrators. To help with this issue, Koster Insurance Agency makes the Basix Dental Savings Program available to you. It is important to understand the ***Dental Savings Program is not dental insurance***. Basix contracts with dentists that agree to charge a reduced fee to students covered under your Koster Insurance Agency plan. The student must pay for the services received at the time of service to receive the negotiated rate.

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

- Make an appointment with a contracted dentist; all the contracted dentists are listed on our website, [www.basixstudent.com](http://www.basixstudent.com).
- Make sure the dental office understands that you have access to the Basix program. We list an administrative contact person for each dentist to help clear up any confusion on the spot. We don't issue a separate identification card for the Basix program. The dentist's office may ask for your health plan identification card to make sure you have access to

the program. If the office needs to check eligibility, call Koster Insurance Agency at 800-457-5599 .

- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

College health is all about helping to develop healthy habits. Our program supports those efforts by making available free downloadable mp3 files.

- Need some exercise? Download one of a dozen stationary bike workouts that range from an easy introduction to a simulated criterium road race. Coached walking routines and treadmill routines are also available.
- Need some sleep? Try one our eight guided imagery and Qigong relaxation downloads.
- Need help with weight management? We have two mp3 files specifically designed to help you maintain a healthy weight, one specifically dealing with the “Freshman 15”.

Full details of the program can be viewed at the website: [www.basixstudent.com](http://www.basixstudent.com). Once at the home page, select the link for your school. You may also contact us via email from our website, or by telephone at (888) 274-9961.

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## **MOUNT HOLYOKE COLLEGE HEALTH CENTER**

The Health Center provides a range of services including an outpatient clinic, mental health counseling, inpatient infirmary, clinical laboratory and x-ray facilities. Physicians, Nurse Practitioners and therapists are on the premises during regular office hours and on call for emergencies. A registered nurse is on duty 8 a.m. to 11 p.m. Monday to Friday and 10 a.m. to 10 p.m. on weekends.

The Mount Holyoke Health Center is available to all Mount Holyoke College students whether or not they are enrolled in the Student Health Plan. Outpatient visits to the Health Center’s medical, nursing and mental health, and substance abuse are provided to all students without charge. However, there are charges for x-ray, laboratory and physical therapy services and infirmary stays longer than 4 hours.

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## **PREPAID ON-CAMPUS HEALTH CARE OPTION**

For students who waive the Student Health Insurance Plan, the College offers an optional Prepaid On-Campus Health Care Option at the Mount Holyoke Health Center while the College is in full session. The Prepaid On-Campus Health Center option provides services at the

Mount Holyoke College Health Center and will cover lab tests, x-rays, physical therapy, and extended nursing care provided on campus. Students will not be billed for any use of the Health Center and services (except for immunizations and prescriptions). However, any charges for referrals or treatment outside of the services provided by the Health Center, including emergency room or ambulance services, are the responsibility of the student and her own insurance company.

The Prepaid On-Campus Health Care Option does not cover: immunizations and prescribed medications, off-campus care, ambulance, and hospital or emergency room visits.

**STUDENT HEALTH  
INSURANCE PLAN  
DESCRIPTION OF  
BENEFITS**

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## **STUDENT HEALTH INSURANCE PLAN**

The Student Health Insurance Plan meets and may exceed the Massachusetts State Law requirements for student health insurance. It expands the coverage provided at the Mount Holyoke College Health Center to provide coverage for the treatment of injuries or illness which are beyond the scope of care available at the Health Center, emergency care, and care while the Health Center is closed or the student is out of the region. Please refer to the Description of Medical Insurance Benefits section for further details.

In order to keep the program as affordable as possible, the College has elected to incorporate managed care practices into the program. This means that all outside care (i.e. non-Health Center) must have a referral from the Health Center (refer to Exceptions to Referral Process). When treatment is obtained from health care providers within the program's Network Providers, preferred rates and coverage schedules are applied.

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## **NETWORK PROVIDERS**

The Mount Holyoke College Student Health Insurance Plan provides access to hospitals and health care providers locally through the Pioneer Health PPO in Western Massachusetts, throughout New England and across the country through the FirstHealth provider network. When Insured Students use Network Providers, out-of-pocket expenses will be less because Network Providers have agreed to accept a negotiated fee or Preferred Allowance as payment. Non-Network Providers have not agreed to a negotiated fee and are subject to a higher coinsurance. Students should be aware that Network Hospitals may be staffed with Non-Network Providers. Receiving services or care from a Non-Network Provider at a Network Hospital means that those charges will not be paid at the Network Provider level of benefits.

It is important that the Insured Student verify that her Doctors are Network Providers when calling for an appointment or at the time of service. The most efficient and accurate way to identify Network Providers is to call FirstHealth toll-free or visit their website. This information is provided in the back of the brochure.

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## **REFERRAL PROCESS**

**When the college is in session, students must first report to the Mount Holyoke Health Center for treatment or for a referral in order for benefits to be paid.** An Insured Student must receive a referral from the Health Center prior to receiving services from any off-campus provider.

## **Exceptions to the Referral Requirement for Insured Students:**

1. Medical Emergency. The Insured Student should return to the Health Center for necessary follow-up care.
2. When the Health Center is closed.
3. Medical care received when the Insured Student is more than 50 miles from campus.
4. Medical care received when the Insured Student is no longer able to use the Health Center due to change in student status.
5. Insured Dependents.

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## **SPORTS INJURY INSURANCE**

The Student Health Insurance Plan is also designed to work in conjunction with the Sports Injury Insurance Policy, which is carried by the College for all Intercollegiate and Club Sports athletes. The Sports Injury Insurance Policy has a \$500.00 deductible which is met by the Student Health Insurance Plan. If a Student waives the Student Health Insurance Plan, and does not have any other coverage, the \$500.00 Sports Injury deductible will be the responsibility of the student. A separate sports insurance brochure is available through Koster Insurance Agency.

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## **DEFINITIONS**

**Coinsurance** means the percentage of the Expenses for which the Insured Person is responsible for a covered service.

**Copayment** means the specified dollar amount an Insured Person must pay for specified charges. The Copayment is separate from and not a part of the deductible or Coinsurance.

**Covered Charges** or **Expense** as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of Reasonable and Customary Expense; (c) not in excess of the charges that would have been made in the absence of this Insurance; and (d) incurred while this Plan is in force as to the Insured Person except with respect to any expenses payable under the Extension of Benefits Provision.

**Deductible** means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

**Doctor** as used herein means: (a) a legally qualified physician licensed by the state in which he or she

practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state or residence of such practitioners; or (c) a podiatrist or optometrist performing covered services rendered within the scope of his or her license; (d) a nurse midwife when such services are within the lawful scope of practice for a certified nurse midwife; (e) a certified registered nurse anesthetist or nurse practitioner designated as such by the board of registration in nursing, if: (i) the service rendered is within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice by the board of registration in nursing; and (ii) the policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth; (f) a chiropractor when performing covered services rendered within the scope of his or her license; or (g) a dentist when performing covered services rendered within the scope of his or her license.

**Elective Treatment** means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage. Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; immunizations; and routine physical examinations.

**Experimental or Investigational Care** means a service or supply: (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or (b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished. We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

**Grievance** means any oral or written complaint submitted to Us or Our authorized TPA that has been initiated by an Insured Person, or an Insured Person's authorized representative, concerning any aspect or action of Combined relative to the Insured Person, including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of 105 CMR 128.000 et seq.

**Hospital** means a facility which meets all of these tests:

- (a) it provides inpatient services for the care and treatment of injured and sick people; and
- (b) it provides room and board services and nursing services 24 hours a day; and
- (c) it has established facilities for diagnosis and major surgery; and
- (d) it is supervised by a Doctor; and
- (e) it is run as a Hospital under the laws of the jurisdiction in which it is located.

**Hospital** does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility

**Injury** means bodily injury caused by an accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

**Insured Person** means an Insured Student and their covered Dependent(s) while insured under this Plan.

**Loss** means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy.

**Medical Emergency** means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an Insured Person or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in 1867(e)(1)(B) of the Social Security Act.

**Medically Necessary** means that a service, drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, Drug or supply is provided. A service, drug or supply shall be considered "needed" if it: (a) is ordered by a licensed Doctor; and (b) is commonly and customarily recognized through the medical profession as appropriate for the particular Injury or Sickness for which it is ordered. A service, drug or supply shall not be considered Medically Necessary if it is investigational, experimental, or educational.

**Network Providers** are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

**Non-Network Providers** have not agreed to any pre-arranged fee schedules.

**Per Condition Aggregate Maximum** means for each Insured Person, the total amount of benefits payable for each Injury or Sickness under the Student Medical Insurance Policy or Policies issued to this Policyholder before this Policy.

**Preferred Allowance** means the amount a Network Provider will accept as payment in full for Covered Services.

**Reasonable and Customary Expense** means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

**Sickness** means sickness or disease, which is the sole cause of the Loss. Sickness includes both normal pregnancy and complications of pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

**We, Us or Our** means Combined Insurance Company of America.

**You, Your or Yours** means the Insured Student.

## SCHEDULE OF BENEFITS

**REFERRAL REQUIREMENT:** When the Health Center is accessible, an Insured Student must receive a referral by the Health Center in order to receive benefits. Refer to page 11 for Exceptions to the Referral Requirement. There is a \$50 deductible per policy year for Network Providers and a \$200 deductible per policy year for Non-Network Providers.

<b>BENEFITS</b>		<b>NETWORK PROVIDER</b>	<b>NON-NETWORK PROVIDER</b>
<b>Per Condition Aggregate Maximum Benefit</b>		\$50,000 Per Condition Aggregate Maximum	
<b>Deductible per Policy Year</b>		\$50.00 deductible for services rendered by a Network Provider \$200.00 deductible for services rendered by a Non-Network Provider	
<b>HOSPITAL EXPENSE BENEFITS</b>			
<b>Hospital Room and Board Expense.</b> Services include semi-private room, nursing services, special care unit		100% of Preferred Allowance	70% of Reasonable and Customary Expense
<b>Hospital Miscellaneous Expense.</b> Services include anesthesia, operating room, diagnostic x-ray, laboratory tests, prescribed drugs & medicines, dressings, supplies, physical & occupational therapy, other necessary prescribed hospital expenses		100% of Preferred Allowance	70% of Reasonable and Customary Expense
<b>In Hospital Doctor's Fees and Medical Expense.</b> Services include visits by a doctor who may or may not have performed surgery		100% of Preferred Allowance	70% of Reasonable and Customary Expense
<b>SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)</b>			
<b>Surgical Expense Benefit,</b> refer to page 20 for multiple surgical procedures expense benefit		100% of Preferred Allowance, up to a maximum of \$5,000 per Accident or Sickness	70% of Reasonable and Customary Expense, up to a maximum of \$5,000 per Accident or Sickness
<b>Assistant Surgeon Expense Anesthetist Expense</b>		100% of Preferred Allowance included under Surgical Expense Benefit	70% of Reasonable and Customary Expense, included under Surgical Expense Benefit
<b>Second Surgical Opinion Consultation Expense,</b> Covered Charges include any required x-rays and diagnostic tests		100% of Preferred Allowance up to \$125.00 Per Accident or Sickness	70% of Reasonable and Customary Expense up to \$125.00 Per Accident or Sickness

<b>BENEFITS</b>		<b>NETWORK PROVIDER</b>	<b>NON-NETWORK PROVIDER</b>
<b>OUTPATIENT BENEFITS</b>			
<b>Outpatient Miscellaneous Expense</b> , Services include diagnostic x-ray & laboratory, physical therapy, durable medical equipment, hospital emergency room, hospital outpatient department, doctor services, chiropractic services and consultant services. <b>Copayments apply when the Health Center is not accessible and student can't be referred.</b>	100% of Preferred Allowance up to a maximum of \$3,000 per Accident or Sickness Office Visit \$15.00 Outpatient Hospital Visit \$15.00 Emergency Room Visit \$100.00 (waived if admitted)	70% of Reasonable and Customary Expense up to a maximum of \$3,000 per Accident or Sickness Office Visit \$15.00 Outpatient Hospital Visit \$15.00 Emergency Room Visit \$100.00 (waived if admitted)	
<b>High Cost Procedure Expense</b> , Services include, but are not limited to CAT scan, MRI, Ultrasound and Laser Treatment	100% of Preferred Allowance up to a maximum of \$3,000 per Accident or Sickness	70% of Reasonable and Customary Expense up to a maximum of \$3,000 per Accident or Sickness	
<b>Treatment and/or Diagnosis of Attention Deficit Disorder</b>	80% of Reasonable and Customary Expense up to \$750.00 per policy year		
<b>Ambulance Expense</b>	100% of Reasonable and Customary Expense up to \$500.00 per condition		
<b>Voluntary Termination of Pregnancy Expense</b>	100% of Reasonable and Customary Expense		
<b>MENTAL ILLNESS EXPENSE (Refer to page 28 for details)</b>			
<b>Inpatient Mental Expense Benefit</b> for Non-Biologically Based Conditions	100% of Preferred Allowance up to 60 days per policy year	70% of Reasonable and Customary Expense up to 60 days per policy year	
<b>Outpatient Mental Illness Expense</b> for Non-Biologically Based Conditions	100% of Preferred Allowance up to 24 visits per policy year	70% of Reasonable and Customary Expense up to 24 visits per policy year	

<b>SCHEDULE BENEFITS</b>		<b>NETWORK PROVIDER</b>	<b>NON-NETWORK PROVIDER</b>
<b>STATE MANDATED BENEFITS (Refer to page 25 for details)</b>			
Bone Marrow Transplant for Treatment of Breast Cancer Expense		Covered as any other Sickness	
Cancer Clinical Trials Expense		Covered as any other Sickness	
Cardiac Rehabilitation Expense		Covered as any other Sickness	
Cytological Screening Expense, including screening and examination		100% of Preferred Allowance	70% of Reasonable and Customary Expense
Diabetic Diagnosis and Treatment Expense		100% of Preferred Allowance	70% of Reasonable and Customary Expense
Early Intervention Services Expense		Covered at 80% of the Actual Expense up to a maximum of \$5,200 per Policy Year and \$15,600 over the over the total enrollment for Early Intervention Services	
Hearing Screening Test Expense		Covered as any other Sickness	
Hearing, Speech and Language Disorder Expense		Covered as any other Sickness	
Hospice Care Treatment Expense		Covered as any other Sickness	
Human Leukocyte Antigen Testing Expense		Covered as any other Sickness	
Infertility Expense		Covered as any other Sickness	
Mammography Examination Expense		Covered as any other Sickness	
Maternity Expense		Covered as any other Sickness	
Non-prescription Enteral Formulas Expense		Covered as any other Sickness up to \$2,500	
Outpatient Hormone Replacement Therapy and Contraceptive Services Expense		Covered as any other Sickness	
Preventive and Children Primary Expense		Covered as any other Sickness	
Scalp Hair Prosthesis Expense		Covered as any other Sickness up to \$350.00 Per Policy Year	

<b>SCHEDULE OF BENEFITS</b>		<b>NETWORK PROVIDER</b>	<b>NON-NETWORK PROVIDER</b>
<b>STATE MANDATED BENEFITS (Con't)</b>			
<b>Services Performed by Certified Registered Nurse Anesthetist and Nurse Practitioners Expense</b>			
<b>Special Medical Formulas Expense</b>		Covered as any other Sickness	
<b>Outpatient Specific Mental Illness Expense for Biologically Based Conditions</b>		Covered as any other Sickness	
<b>Inpatient Specific Mental Illness Expense for Biologically Based Conditions</b>		100% of Preferred Allowance up to \$3,000 per condition	70% of Reasonable and Customary Expense up to \$3,000 per condition
<b>Medication Management Expense</b>		100% of Preferred Allowance	70% of Reasonable and Customary Expense
<b>Inpatient Alcohol and Drug Abuse Expense</b>		Covered under Outpatient Miscellaneous Expense	
<b>Outpatient Alcohol and Drug Abuse Expense</b>		100% of Preferred Allowance up to 30 days per policy year or the per condition aggregate maximum	70% of Reasonable and Customary Expense 30 days per policy year or the per condition aggregate maximum
<b>Outpatient Alcohol and Drug Abuse Expense</b>		100% of Preferred Allowance up to a maximum of \$750.00 per policy year	70% of Reasonable and Customary Expense up to a maximum of \$750.00 per policy year
<b>ADDITIONAL BENEFITS</b>			
<b>Accident Dental Expense, injury to sound natural teeth</b>		100% of R&C Expense, maximum \$350.00 per tooth, up to a maximum of \$1,000 per Injury	
<b>Sickness Dental Expense, impacted wisdom teeth and dental abscesses</b>		100% of R&C Expense up to a maximum of \$100.00 per tooth	
<b>Intercollegiate Sports Accident Expense</b>		100% of Actual Expenses incurred up to a maximum of \$500.00 per Injury	
<b>Prescription Drug Expense, Including prescription contraceptive drugs and devices</b>		\$10.00 for a 30-day supply of a generic drug or \$25.00 for a 30-day supply of a preferred brand name drug or \$45.00 for a 30-day supply of a non-preferred brand name drug up to \$1,500 per policy year. Prescriptions must be filled at an Express Script pharmacy	
<b>Home Health Care</b>		After a \$50.00 deductible, covered as any other Sickness	

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## **DESCRIPTION OF MEDICAL INSURANCE BENEFITS**

Payment will be made as allocated herein for covered medical expenses incurred for an Injury or Sickness while insured under this Plan, not to exceed the Per Condition Aggregate Maximum of \$50,000. There is a \$50 per policy year deductible for Network Providers and a \$200 per policy year deductible for Non-Network Providers. **When the Health Center is accessible, an Insured Student must receive a referral by the Health Center to receive benefits from either a Network or a Non-Network Provider.**

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## **HOSPITAL EXPENSE BENEFIT**

- **Hospital Room and Board Expense Benefit**

When, by reason of Injury or Sickness, an Insured Person requires Hospital Confinement, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers of the Hospital room and board Covered Charge for a semi-private room containing two or more beds including meals, special diets and nursing services incurred for the period of such Hospital Confinement. Coverage includes a bed in a special care unit.

- **Miscellaneous Hospital Expense Benefit**

Miscellaneous Hospital Expense includes expenses incurred for: anesthesia, anesthesia supplies and services; operating, delivery and treatment rooms and equipment; diagnostic X-ray and laboratory tests; lab studies; oxygen tent; blood and blood services; prescribed drugs and medicines; medical and surgical dressings, supplies, casts and splints; radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; intravenous injections and solutions, and their administration; physical and occupational therapy; and other necessary and prescribed hospital expenses. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense for Non-Network providers incurred by the Insured Person during the period of Hospital Confinement.

- **In Hospital Doctor's Fees and Medical Expense Benefit**

When, by reason of Injury or Sickness an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for

Non-Network Providers. The following medical services performed by a Doctor are covered on an inpatient basis: (a) one Doctor visit per day; (b) constant care and treatment while an Insured Person is confined intensive care unit; (c) care by two or more Doctors during one Hospital stay when the Insured Person's condition requires the skill of separate Doctors; (d) consultation by another Doctor when requested by the Insured Persons' Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.

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## **SURGICAL EXPENSE BENEFIT (INPATIENT OR OUTPATIENT)**

- **Surgery Expense Benefit**

When by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient or outpatient basis, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers up to a maximum of \$5,000 per Injury or Sickness, in conjunction with any one Surgical Procedure.

**Surgical Expense** means charges by a Doctor for: (a) a Surgical Procedure; (b) necessary pre-operative treatment during a Hospital stay in connection with such procedures; and (c) usual post-operative treatment.

**Surgical Procedure** means: (a) a cutting procedure; (b) suturing of a wound; (c) treatment of a fracture; (d) reduction of a dislocation; (e) radiotherapy; (f) electrocauterization; (g) diagnostic and therapeutic endoscopic procedures; (h) injection treatment for hemorrhoids and varicose veins; (i) an operation by means of a laser beam.

- **Multiple Surgical Procedures Expense Benefit**

When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charges of the most expensive Surgical Procedure being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50 percent of the Covered Percentage of the Covered Charge for these procedures.

- **Anesthesia Expense Benefit**

If, in conjunction with such operation, the Insured Person requires the services of an anesthetist, We will pay 100% of the Preferred Allowance for

Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers. The Expense incurred will be included with the maximum under the Surgical Expense.

- **Assistant Surgeon Expense Benefit**

If, in conjunction with such operation, the Insured Person requires the services of an assistant surgeon, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers. The Expenses incurred will be included with the maximum under the Surgical Expense.

- **Second Surgical Opinion Consultation Expense**

We will also provide benefits to an Insured Person for a second opinion consultation by a board certified specialist on the need for a non-emergency surgery which has been recommended by the Insured Person's Doctor, We will pay 100% of the Preferred Allowance for Network Providers and 70% of Reasonable and Customary Expense for Non-Network Providers incurred up to a maximum of \$125.00 per Injury or Sickness. The Specialist must be board certified in the medical field relating to the surgical procedure being proposed. Benefits will also be provided for any required X-rays and diagnostic tests done in connection with that consultation.

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## **OUTPATIENT EXPENSE BENEFITS**

If, by reason of Injury or Sickness, an Insured Person incurs expenses in a Doctor's office, Hospital outpatient department, emergency room, clinical lab, radiological facility, or other similar facility licensed by the state, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense for Non-Network Providers up to a maximum of \$3,000 per Injury or Sickness per policy year, subject to the copayments below

- **Outpatient Miscellaneous Expense**

Covered Charges for "Outpatient Services" are charges for the following services: (a) Doctor's office while not Hospital Confined; (b) chiropractic care; (c) Hospital outpatient department or emergency room; (d) diagnostic x-ray and laboratory testing; (e) blood and blood services, if provided and billed by a Hospital or other facility; (f) physical and occupational therapy; (g) radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy; (h) radiological lab or other similar facility licensed by the state; (i) surgical dressings, splints, casts, and other devices used to correct fractures and dislocations, (j) diabetic supplies.

**Copayments when the Health Center is not accessible and the student cannot be referred are as follows:**

Doctor Office Visit	\$15.00 per visit
Hospital Outpatient Department	\$15.00 per visit
Hospital Emergency Room	\$100.00 per visit (when not admitted as an inpatient)

- **High Cost Procedure Expense**

High Cost Procedures, as used herein, means an outpatient procedure costing over \$200.00. Covered Charges for “High Cost Procedures” include, but not limited to, charges for the following procedures and services. (1) C.A.T. Scan; (2) Magnetic resonance imaging; and (3) Laser treatment. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers up to a maximum of \$2,000 per Injury or Sickness. If, by reason of similar benefit provision elsewhere contained, the Policy provides reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of the Policy. If the Outpatient Services are in connection with surgery and the Doctor is the surgeon who performed or is to perform the surgery, no benefits are payable under this provision. All surgery charges are paid under the Surgical Expense Benefits provision.

For services normally provided without charge by this Policyholder’s health service, infirmary, or Hospital, or by Health Care Providers employed by this Policyholder, no benefits are payable under this Outpatient Expense Benefit provision.

- **Treatment and/or Diagnosis of Attention Deficit Disorder**

If an Insured Student requires evaluation and testing for ADD, We will pay 80% of the Reasonable and Customary Expense incurred up to \$750.00 per policy year. A referral is required by the Health Center.

- **Ambulance Expense**

When, by reason of an Injury or Sickness, an Insured Person requires the use of a community or hospital ambulance, We will pay 100% of the Reasonable and Customary Expense incurred up to a maximum of \$500.00 per Injury or Sickness.

- **Voluntary Termination of Pregnancy Expense**

If, as a result of pregnancy having its inception during the term insured, an Insured Person has a voluntary termination of pregnancy, We will pay 100% of the Reasonable and Customary Expense incurred. Expenses for the voluntary termination

of pregnancy must be incurred while the Plan is in force as to the Insured Person.

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## **ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT**

If an Insured person requires treatment on account of alcoholism, alcohol abuse, drug abuse or drug dependent, We will pay for such treatment as follows:

- **Benefits for Inpatient Confinement**

When the Insured Person is confined for inpatient treatment, We will provide expenses for treatment in an accredited or licensed hospital, public or private facility, or residential alcohol treatment program providing services for the detoxification or rehabilitation of intoxicated persons or alcoholics which is licensed by the Department of Public Health. We will pay 100% of the Preferred Allowance for Network Providers or 70% of Reasonable and Customary Expense for Non-Network Providers incurred for such Hospital Confinement on the same basis as any other Sickness, but payment will not be made for more than 30 days in a Plan Year.

If charges are incurred in connection with a Mental Illness, the above limits will not apply.

Where medically appropriate, two days of outpatient day treatment may be submitted for one day of inpatient Hospital care.

- **Benefits for Outpatient Services**

We will pay 100% of the Preferred Allowance for Network Providers and 70% of Reasonable and Customary Expense for Non-Network Providers for covered outpatient services for the rehabilitation of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency up to a maximum of \$750.00 per Policy Year.

Outpatient benefits include services furnished by: (a) an accredited or licensed Hospital; (b) a public or private facility provided services for the rehabilitation of alcoholics licensed by the Department of Public Health; and (c) a licensed Doctor or psychologist.

- **Alcohol Abuse.** This term means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

**Detoxification Facility.** This terms means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social, and emotional needs of the individual by: (a) monitoring the amount of alcohol and other toxic

agents in the body of the individual; (b) managing withdrawal symptoms; and (c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol or Drug Abuse.

**Psychotherapist.** This term means a person fully licensed to practice medicine and who devotes a substantial portion of his time to practice psychiatry.

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## DENTAL CARE EXPENSE BENEFITS

- **Accidental Dental Expense**

We will pay the Reasonable and Customary Expense incurred for dental treatment as a result of accidental Injury to sound natural teeth up to a maximum of \$350.00 per tooth, up to a maximum of \$1,000 per Injury.

- **Sickness Dental Expense**

If an Insured Person requires the services of a Doctor for the removal of impacted wisdom teeth, or for treatment of dental abscesses, We will pay the Reasonable and Customary Expense incurred up to a maximum of \$100.00 per tooth.

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## ADDITIONAL BENEFITS

- **Intercollegiate Sports Accident Expense**

If an Insured Student is injured during the supervised practice, supervised off-season conditioning, travel to and from play, or during play of an Intercollegiate Sport, We will pay 100% of the Actual Expenses incurred up to a maximum of \$500.00 per Injury.

- **Outpatient Prescription Drug Expense**

The outpatient prescription drug benefit is available through the Express Scripts Pharmacy Network. The Express Scripts Network includes national pharmacy chains, CVS, Walgreens, Brooks, etc. and local independent pharmacies, such as Louis and Clark. After a per prescription copayment of \$10.00 for a 30 day supply of a generic drug or a per prescription copayment of \$25.00 for a 30 day supply of a preferred brand name drug or a \$45.00 for a 30-day of a non-preferred brand name drug, the Expenses incurred for the cost of prescription drugs will be reimbursed at 100%, up to a maximum of \$1,500 per policy year. Insured Persons will need to present their ID card to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving an ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained from Koster Insurance Agency or Mount Holyoke College Health Center). To locate an Express Scripts Participating Pharmacy call 1-877-868-9060 or go

to [www.Express-Scripts.com](http://www.Express-Scripts.com). Not all medications are covered (See Exclusion Section).

### **Mail Service Prescription Drug Program**

Medications that are taken for a chronic condition can be filled for up to a 90-day supply using Express Scripts' Mail Service Prescription Drug Program. Using the Mail Service Prescription Drug Program, a 90-day supply of a generic medication can be filled with a copayment that is 2 times the copayment of a generic 30-day supply. When you use the Mail Service Prescription Drug Program you will need to complete an "Express Scripts By Mail" Order Form and mail it directly to Express Scripts along with your doctor's signed prescription form. A brochure describing the Mail Service Prescription Drug Program, order forms, and accompanying mailing envelope are available by contacting Koster Insurance Agency.

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## **STATE MANDATED BENEFITS**

- **Bone Marrow Transplant for Treatment of Breast Cancer Expense Benefit:** If an Insured Person has metastatic breast cancer, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network providers for Covered Charges up to the Aggregate Maximum for the expense of a bone marrow transplant for the treatment of breast cancer.
- **Cancer Clinical Trials Expense Benefit:** We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for Patient Care Service to an Insured Person engaging in a cancer clinical trial, as a result of: (a) treatment provided for a life-threatening condition; or (b) prevention, early detection, and treatment studies on cancer.
- **Cardiac Rehabilitation Expense Benefit:** If an Insured Person requires Cardiac Rehabilitation treatment in connection with documented cardiovascular disease, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses. Such treatment shall include, but is not limited to, outpatient treatment which is to be initiated within 26 weeks after the diagnosis of such disease.
- **Cytological Screening Expense Benefit:** We cover charges for a Cytologic Screening (Pap smear) for an Insured Person 18 years of age or older. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for

one annual Cytologic Screening, or more frequently, if recommended by a Doctor. Such benefit will include the examination, laboratory fee and the Doctor's interpretation of the laboratory results.

- **Diabetes Diagnosis and Treatment Expense Benefit:** We will pay the 100% of the Preferred Allowance for Network Providers and 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for the diagnosis and treatment of Diabetes if prescribed by a health care professional legally authorized to prescribe the following Medically Necessary items: a) insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes; b) blood glucose monitors; c) blood glucose monitoring strips for home use; d) voice synthesizers for blood glucose monitors for use by the legally blind; e) visual magnifying aids for use by the legally blind, urine glucose strips, ketone strips; f) lancets; g) insulin; h) insulin syringes; i) prescribed oral diabetes medications that influence blood sugar levels; j) laboratory tests, including glycosylated hemoglobin, or HbA<sub>1c</sub>, test; k) urinary protein/microalbumin and lipid-profiles; l) insulin pumps and insulin pump supplies; m) insulin pens; so-called; n) therapeutic/molded shoes and inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and insets have been certified by the treating Doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prothetist or pedorthist; o) supplies and equipment approved by the Federal Drug Administration for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a Certified Diabetes Health Care Provider participating with the insurance contract or affiliated with a provider participating with the insurance contract.

**Certified Diabetes Health Care Provider** means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

- **Early Intervention Services Expense:** We will pay 80% of the Expense actually incurred up to a maximum of \$5,200 per policy year and \$15,600 over the total enrollment for Early Intervention Services. These services include occupational, physical, speech therapy; nursing care and psychological counseling. Expenses are payable for a dependent child of an Insured Person from birth until their third birthday.

- **Hearing Screening Test Expense:** We cover charges for a newborn Hearing Screening Test to be performed before the newborn infant is discharged from the Hospital or birthing center. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.
- **Hospice Care Treatment Expense:** We pay for charges made by a licensed hospice for the Covered Expenses for an Insured Person with a life expectancy of six months or less. Services must be authorized by a duly licensed physician. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.
- **Human Leukocyte Antigen Testing Expense:** We cover charges for Human Leukocyte Antigen Testing or Histocompatibility Locus Antigen Testing necessary to establish bone marrow transplant donor suitability. Coverage shall include testing for A, B, or DR antigens, or any combination thereof, consistent with the guidelines, criteria, and rules or regulations established by the Department of Public Health. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.
- **Infertility Expense:** If an Insured Person incurs medically necessary expenses for diagnosis and treatment of infertility, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses. Covered Charges include expense incurred for the following non-experimental infertility procedures: (1) Artificial Insemination; (2) In Vitro Fertilization and Embryo Placement; (3) Sperm, egg and/or inseminated egg procurement, processing and banking to the extent such costs are not covered by the donor's insurer, if any; (4) Gamete Intra-Fallopian Transfer; (5) Intracytoplasmic Sperm Injection for the treatment of male factor infertility; and (6) Zygote Intrafallopian Transfer. The term "Infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.
- **Mammography Examination Expense:** We will pay the Covered Percentage of the Covered Charges incurred for a mammographic exam. The charges must be incurred while the Insured Person is insured for these benefits. Benefits will be paid for mammographic exam charges incurred for the following: (a) one baseline mammogram for a

woman thirty-five through thirty-nine years of age; and (b) one mammogram every twelve months for a woman forty years of age or older. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.

- **Maternity Expense:** We will pay benefits for an Insured Persons' Covered Charges for maternity care, including Hospital, surgical, and medical care. We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital.

We will pay for post-delivery care which includes but not limited to home visits, parent education, assistance and training in breast or bottle feeding, the performance of any necessary and appropriate clinical tests, provided the first home care visit is conducted by a registered nurse, Doctor, or by a certified nurse midwife under qualified medical director if he or she is affiliated with or practicing in conjunction with a licensed health care provider.

We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.

- **Mental Illness Expense Benefit**
  - **Inpatient Mental Illness Expense Benefit:** When an Insured Person requires hospital confinement for the treatment of a Mental Illness, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers. But, We will not cover more than sixty (60) days per Policy Year for such inpatient care. Inpatient benefits are covered if provided in (a) a mental hospital under the direction and supervision of the Department of Mental Health; or (b) a private mental hospital licensed by the Department of Mental Health; or (c) a general hospital licensed to provide such services. If charges are incurred in connection with treatment for alcoholism, the above limits will not apply.
  - **Intermediate Services Expense Benefits:** We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses incurred for Intermediate Services including but not

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.

Where medically appropriate, a period of confinement may be calculated by substituting two days of outpatient treatment at a community mental health center or other mental health clinic or psychiatric day treatment center licensed by the Department of Public Health, or two days of outpatient day treatment at a psychiatric hospital licensed by the Department of Mental Health, for one day of inpatient hospital care.

- **Outpatient Mental Illness Expense Benefit:** When an Insured Person requires outpatient treatment for a Mental Illness, We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses. However, We will not pay more than 24 visits per Policy Year for such outpatient services. No other limitations, Coinsurance, Copayment, Deductibles or other cost sharing may be applied unless such limitations also apply to Expenses for treatment of conditions that are not mental or nervous conditions.

Outpatient services may be provided in the following facilities: (1) licensed hospital; (2) community mental health center; (3) mental health clinic, licensed by the Department of Public Health; (4) psychiatric day treatment center, licensed by the Department of Public Health; (5) professional office, or home-based services provided by the following licensed mental health professionals acting within the scope of his or her license: (a) a licensed Doctor who specializes in the practice of psychiatry, (b) a licensed psychologist or licensed Psychotherapist; (c) a licensed independent clinical social worker, a licensed mental health counselor, or (d) a licensed nurse mental health clinical specialist. If charges are incurred in connection with treatment for alcoholism, the above limits will not apply.

**Psychotherapist** means a person fully licensed to practice medicine and devote a substantial portion of his time to the practice of psychiatry.

- **Specific Mental Disorders Expense Benefit**
  - **Biologically Based Mental Disorders**
    - (a) schizophrenia; (b) schizoaffective disorder; (c) major depressive disorder; (d) bipolar disorder; (e) paranoia and other psychotic

disorders; (d) obsessive-compulsive disorder; (e) panic disorder; (f) delirium and dementia; (g) affective disorders; and (h) any biologically-based mental disorders appearing in 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. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.

- **Rape Related Mental or Emotional Disorders**

We cover the diagnosis and treatment of rape-related mental or emotional disorder to victims of rape or victims of an assault with intent to commit rape, whenever the cost of the diagnosis and treatment exceed the maximum compensation awarded to the victim under the crime victim's compensation law. We cover such charges the same way We treat Covered Charges for any other Sickness.

- **Non-Biologically Based Mental, Behavioral or Emotional Disorders that substantially limit the functioning and social interactions of children and adolescents under the age of 19.**

We cover charges for the diagnosis and treatment of which substantially interfere with or substantially limit the functioning and social interactions of a child or adolescent provided that the interference or limitation is documented and referred for treatment by a Doctor, a primary pediatrician or a licensed mental health professional, or be evidenced by conduct including, but not limited to an inability to attend school as a result of the disorder, the need to hospitalize the child or adolescent as a result of the disorder, or a pattern of conduct caused by the disorder that poses a serious danger to self or others. Treatment may continue beyond the adolescent's 19th birthday until the course of treatment is completed, provided the plan under which the benefits first became available remains in effect, or are subject to a subsequent health plan that is in effect. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.

- **Psychopharmacological Services and Neuropsychological Assessment Services**

Services must be treated as medical benefits and must be covered to the same extent as all other medical services. Benefits will be subject to deductibles, coinsurance, plan maximums and

other policy provisions, the same as any other illness. The complete description of each can be found in the Master Policy on file at the College.

- **Non-prescription Enteral Formulas Expense:** We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers up to \$2,500 per policy year for benefits for non-prescription enteral formulas 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 disease of amino acids and organic acids.
- **Outpatient Hormone Replacement Therapy and Contraceptive Services Expense:** We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for Outpatient Hormone Replacement Therapy Services for pre and post-menopausal women and Outpatient Contraceptive Services. Outpatient Contraceptive Services includes consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the FDA.
- **Preventive and Primary Care Services for Children Expense Benefit:** We will pay 100% of the Preferred Allowance for Network Providers or 70% of Reasonable and Customary Expense incurred for Non-Network Providers for expenses incurred for preventive and primary care. These are for services rendered to a dependent child of an Insured Person from the date of birth through the attainment of six years of age. These services are limited to the following: 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, annual until age six. Such services will 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 Doctor.
- **Prosthetic Device Expense Benefit:** We cover charges for artificial limbs on the same basis as any other Injury or Sickness.
- **Scalp Hair Prosthesis Expense:** We cover charges for Scalp Hair Prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or

leukemia. We cover such charges up to a maximum of \$350 in a Plan Year. Coverage must be subject to a written statement by the treating Doctor that the Scalp Hair Prosthesis is Medically Necessary.

- **Services Performed By Certified Registered Nurse Anesthetists and Nurse Practitioners Expense:** We pay for services by Nurse Practitioners and Certified Registered Nurse Anesthetists (CRNA) if the service performed is within the scope of the nurse practitioner's authority to practice or the CRNA's license and if the Plan currently provides benefits for identical services rendered by a health care provider licensed in Massachusetts. We will pay 100% of the Preferred Allowance for Network Providers or 70% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.
- **Special Medical Formulas Expense:** We cover charges for special medical formulas for newborns and adoptive children which are: 1) approved by the Commissioner of the Department of Public Health; 2) prescribed by a Doctor; and 3) are Medically Necessary for the treatment of Phenyketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia or methymalonic acidemia in infants and children; or 4) are Medically Necessary to protect the unborn fetuses of pregnant women with phenylketonuria. Screening for lead poisoning will also be covered. We will pay 100% of the Preferred Allowance for Network Providers and 70% of the Reasonable and Customary Expense for Non-Network Providers for such Expenses.

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## EXCLUSIONS AND LIMITATIONS

### Pre-existing Conditions

A Pre-existing Condition is a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended or received by a Doctor during the six (6) consecutive months prior to the Effective Date of the Insured Person's coverage under this policy.

The Pre-existing Condition Waiting Period is six (6) months. Except for a Medical Emergency, coverage will not be provided for a Pre-existing Condition until the waiting period has elapsed. The Pre-existing Condition Waiting Period applies to all persons covered under this Policy and begins on the Insured Person's Effective Date.

If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will pay benefits for such condition up to \$2,500 per condition until the day after a six (6) consecutive month period has passed from

the Insured Student's effective date; and (b) We will pay only Loss or Expense incurred after such six (6) consecutive month period.

A period of Creditable Coverage will be credited if the previous Creditable coverage was continuous to a date not more than 63 days prior to the Effective Date of the new coverage.

Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage, the Pre-existing Condition Waiting Period will have to be satisfied again.

### **Creditable Coverage**

This term means the following medical, hospital, and surgical coverage an Insured Person had prior to the Effective Date under this Policy.

(a) an employee group health plan; (b) health plan including but not limited to, a health plan issued, renewed or delivered within or without the Commonwealth to a natural person who is enrolled in a qualifying student health insurance program in this state or of another state; (c) Medicare; (d) Medicaid; (e) Chapter 55 of title 10, United States Code. (CHAMPUS); (f) a medical care program of the Indian Health Services or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under the Federal Employee Health Benefits Program; (i) a public health plan as defined under Federal regulations; (j) a health benefit plan under Section 5(e) of the Peace Corps Act; (k) any other similar coverage permitted under State/Federal law or regulations; (l) any other Creditable Coverage as defined by subsection (c) of section 2701 of Title XXVII of the Federal Public Health Services Act; or (m) any other publicly sponsored program, provided in this state or elsewhere, or medical, hospital and surgical care.

### **Exceptions to Pre-Existing Conditions**

The Pre-existing Condition exclusion does not apply to any of the following: (a) pregnancy, including complications, if such condition is covered under this Policy; (b) a covered newborn dependent child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or (c) a covered adopted dependent child under the age of 18, who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage (except this shall not apply to coverage the adopted child may have had before such adoption or placement).

### **Continuous Insurance**

**Prior Plan** means (a) the Student Health Insurance policy or policies issued to the Policyholder

immediately before the current Policy; and (b) other policies providing Qualifying Previous Health Coverage as defined in this Policy. Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy. Also, the total amount of benefits payable for Injury or Sickness under this Policy and the Prior Plan cannot exceed the Per Condition Aggregate Maximum. Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.

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## **EXCLUSIONS**

This Plan does not cover nor provide benefits for:

1. Services normally provided without charge by the Policyholder's health service, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Preventative medicine, serums, immunizations, or vaccine, except as specifically provided;
3. Pre-existing Conditions as defined in this Plan, not to exceed \$2,500 per Injury or Sickness for a six month period;
4. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any Country, We will refund the unearned pro-rated premium to such Insured Person;
5. Illness, Accident, treatment or medical condition arising out of the play or practice of intercollegiate sports, in excess of \$500.00;
6. Injury resulting from a motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;
7. Cosmetic surgery, except as the result of covered Injury occurring while the Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;

8. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
9. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth;
10. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;
11. Injury or Sickness resulting from declared or undeclared war, or any act thereof;
12. Injury due to participation in a riot;
13. For services rendered by a Doctor who is a close relative to the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brothers or sisters;
14. For services, supplies or treatment; including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;
15. Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, and contact lenses (except when required after cataract surgery), other vision or hearing aids, except as required for repair caused by a covered Injury;
16. Well baby care, including routine exams and immunizations, except as specifically provided;
17. Routine periodical physical examinations, except as specifically provided;
18. Treatment in a government hospital unless there is a legal obligation to pay such charges in the absence of insurance;
19. An amount of a charge in excess of the Reasonable and Customary Expense;
20. Elective Treatment or elective surgery, except as specifically provided;
21. Services not Medically Necessary;
22. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regularly published schedules on a regularly established route;
23. Treatment of mental or nervous disorders except as specifically provided;
24. Treatment of alcohol and substance abuse except as specifically provided;

25. Expense incurred from tubal ligation, vasectomy, breast implants, breast reduction surgery, sexual reassignment, impotence (organic or otherwise), non-prescription birth control, submucous resection and/or other surgical correction for deviated nasal septum other than required treatment for acute purulent sinusitis, circumcision, gynecomastia, hirsutism, treatment of learning disorders and Attention Deficit Disorder except as specifically provided;
26. Expenses incurred for: legend vitamins or food supplements; immunization agents, smoking deterrents, biological sera, blood plasma, drugs to promote or stimulate hair growth, experimental drugs and drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit.

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## **REIMBURSEMENT & SUBROGATION**

If We pay covered expenses for an accident or injury You incur as a result of any act or omission of a third party, and You later obtain recovery from the third party, You are obligated to reimburse Us for the expenses paid. We may also take subrogation action directly against the third party. Our Reimbursement rights are limited by the amount You recover. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

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## **EXTENSION OF BENEFITS**

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 the Plan, but only while they are incurred during the 90 day period following such termination of insurance. If an Insured Person is not confined to a hospital on the date his or her insurance terminates, charges incurred during the next 31 days shall be covered under this Plan, but only for an Injury or Sickness for which covered expenses were incurred before the termination date.

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## **COORDINATION OF BENEFITS**

This Plan is subject to the Coordination of Benefits provision outlined in the Master Policy. For a complete description, please see the Master Policy.

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## **INQUIRY & GRIEVANCE PROCEDURES**

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.

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 Management System, Inc. (Our Administrator) and speak with a Customer Service Representative. You may reach customer service at Pioneer Management System, Inc. by calling: (877) 868-9060. We will attempt to resolve your inquiry to your satisfaction within three (3) business days of the Inquiry.

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. To initiate a Grievance by telephone, call Pioneer Management System, Inc. at (877) 868-9060 and ask to speak with a Patient Advocate.

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. 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.

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. 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. You may also request an expedited External Review by including a certification, in writing, from Your Doctor, that delay will pose a serious and immediate threat to Your health.

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](http://www.state.ma.us/dph/bhqm).

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## **CLAIMS PROCEDURES**

In the event of an Injury or Sickness the Insured Person should:

1. If at Mount Holyoke College and you are an Insured Student, report immediately to the Health Center so that proper treatment can be prescribed or approved, or
2. If away from Mount Holyoke College or the Health Center is closed, report to the nearest Doctor or Hospital and follow the prescribed treatment advice. The Insured Student should return to the Health Center for any necessary follow up care.
3. A claim form is not required to submit a claim. However, an itemized bill, HCFA 1500, or UB92 form should be used to submit expenses. If a referral was required, this form should accompany this submission. The Insured Student/Person's name and identification number need to be included.
4. Providers should submit claims within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. If a student is submitting the claim, a copy should be retained and claims should be mailed to the Claims Administrator, Pioneer Management Systems, Inc. at the address on the back cover.
5. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Pioneer Management Systems, Inc.
6. If you disagree with a claim payment decision, an Insured Person has the right to file an appeal. The process to file an appeal is as follows: (a) you must notify Pioneer Management Systems, Inc. within 30 days of the denial. Your claim appeal must be in writing, and clearly state that you are appealing the decision and requesting another review of your claim; and (b) your written appeal should provide specific documentation as to why you believe the decision to be in error, and any new medical information that will be helpful to Pioneer Management Systems, Inc. in considering the claim. Pioneer Management Systems, Inc. will respond in writing as to their decision.

**REMEMBER THAT EACH INJURY OR SICKNESS REQUIRES A SEPARATE REFERRAL FORM EACH POLICY YEAR.**

Any provisions of this Policy, which on its effective date, is in conflict with the statutes of the state in which the Policy is issued will be administered to conform with the requirements of the state statutes.

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**HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION**

Under HIPAA's Privacy Rule, We are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your enrollment materials. If, at anytime, you wish to request a copy of Combined Insurance Company of America's Privacy Notice, write to 5050 Broadway, Chicago, IL 60640, Attn: HIPAA Privacy Office or call 1-800-225-4500, select HIPAA.

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## QUESTIONS? NEED MORE INFORMATION?

For general information on benefits, on enrollment/eligibility, ID cards, or service issues, please contact:

**Koster Insurance Agency**

500 Victory Road  
Quincy, MA 02171  
1-800-457-5599

Email: [MtHolyokeStudent@Kosterins.com](mailto:MtHolyokeStudent@Kosterins.com)

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

**Pioneer Management Systems, Inc.**

PO Box 9040  
West Springfield, MA 01090  
1-877-868-9060

Email: [student@pioneerhealth.com](mailto:student@pioneerhealth.com)

For information on Network Providers, please contact:

**Pioneer Health PPO**

1-877-868-9060  
[www.pioneerhealth.com](http://www.pioneerhealth.com)

**First Health**

1-888-685-7774  
[www.firsthealth.com](http://www.firsthealth.com)

For information about the Express Scripts Prescription Drug Program, please contact:

**Pioneer Management Systems, Inc.**

1-877-868-9060  
[www.Express-Scripts.com](http://www.Express-Scripts.com)

For information on EyeMed, please contact:

**EyeMed**

1-866-8EYEMED  
[www.enrollwiththeyemed.com](http://www.enrollwiththeyemed.com)

For information on the Dental Savings Plan, please contact:

**Basix Dental**

[www.basixstudent.com](http://www.basixstudent.com)

This policy is Underwritten by:

**Combined Insurance Company of America**

Policy Number: CUH201393

A Master Policy is available for review at Mount Holyoke College. In the event of any conflict between this description of services provided and the Policy, the Master Policy will control.