2003-2004
STUDENT
ACCIDENT AND
SICKNESS
INSURANCE PROGRAM

Designed For
Graduate Students of
Babson College

Underwritten by:
GUARANTEE TRUST LIFE INSURANCE COMPANY
Policy Number: 204-163-001R
One Year MBA effective date 5/19/2003 to 8/18/2004
MBA (not One Year) effective date 8/18/03 to 8/18/2004

NON-DISCRIMINATORY
Health care services and any other benefits to which a Covered Person is entitled are provided on a nondiscriminatory basis, including benefits mandated by state and federal law.

We will notify Covered Persons of all material changes to this policy.

IMPORTANT NOTICE
This brochure provides a brief description of the important features of the Policy. It is not a Policy. Terms and conditions of the Coverage are set forth in the Policy. We will notify Covered Persons of all material changes to the Policy. Please keep this material with your important papers.
Dear Students:

The Student Health Insurance Plan for Babson College students, underwritten by Guarantee Trust Life Insurance Company, will be effective on August 18, 2003 for MBA (Not One Year MBA) Students and May 19, 2003 for One Year MBA Students.

We believe that the Student Health Insurance Plan will provide reasonable protection against expensive illness and accidents at a cost low enough so as not to constitute an undue burden on anyone.

Participation in the Student Health Insurance Plan is required of all students who are registered for nine or more credits each semester and all international students who are not embassy sponsored unless they are covered under another comparable plan. All students must annually submit a waiver form by logging onto www.universityhealthplans.com. Babson College is mandated to enroll all students who do not show proof that they have insurance and to bill them the cost of the premium. Please note that there are different waiver deadlines for different groups of Graduate Students. Please refer to the Waiver/Enrollment Process section of the brochure for specific deadlines.

This brochure has been prepared to provide a description of the Student Health Insurance Plan. It also describes some of the services available at Babson College Health Services for all full-time students.

You can obtain additional information about Babson College Health Services at www.babson.edu/health. Additional information regarding University Health Plans may be found on the Health Services web page or at www.universityhealthplans.com.

Sincerely,

Thelma Lake, MS, RNC-NP
Health Services
Babson College
THE BABSON COLLEGE STUDENT HEALTH INSURANCE PLAN

The Babson Student Health Insurance Plan has been developed especially for Babson full-time students. The Plan provides coverage for illnesses and injuries that occur on and off campus, and includes special cost saving features to keep the coverage as affordable as possible. Babson is pleased to offer the Plan, as described in this Brochure, to students.

WHERE TO FIND HELP

For questions about:
- Insurance Benefits
- Claims Processing
Please contact:
Consolidated Health Plans
195 Stafford Street
Springfield, MA 01104-3503
(800) 633-7867
www.consolidatedhealthplan.com

For questions about:
- Enrollment
- Waiver/Enrollment Process
Please contact:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
Phone: (800) 437-6448
Fax: (617) 472-6419
www.universityhealthplans.com
email: info@univhealthplans.com

For questions about:
- Lost ID Cards
Please Contact:
Consolidated Health Plans
(800) 633-7867

If you need medical attention before you receive your ID card, inform your healthcare provider that your insurance coverage is Guarantee Trust Life Insurance Company. Benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

For questions about:
On-campus Health Services
Please contact:
Health Services
(781) 239-4257
www.babson.edu/health
Medical Claim Forms and Pharmacy Claim Forms are also available at Health Services.

For questions about:
- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs
Please contact:
Express Scripts
(800) 451-6245
For Provider Listings
A complete list of Providers can be found at the Babson College Health Services, or by going to

Worldwide Web Access:
Consolidated Health Plans
www.consolidatedhealthplan.com
University Health Plans, Inc.
www.universityhealthplans.com

BABSON COLLEGE HEALTH SERVICES
Student health care needs can best be satisfied and cost contained with an organized system of health care providers at Babson College Health Services. If you are enrolled in the Student Health Insurance Plan, you should always attempt to use Babson College Health Services first to maximize all of your Student Health Benefits. Certain benefits may be reduced if you do not utilize Health Services. (See the Description of Benefits in this Brochure).

Located on the ground floor of the Hollister Building, Health Services is committed to maintaining and improving student health through preventative, diagnostic, and therapeutic care. The professional staff includes a team of nurse practitioners, registered nurses, a part-time physician, and a health educator. When appropriate, referrals are made to independent health care providers and specialists. Health Services is open weekdays from 8:00 a.m. to 6:00 p.m. during the Fall and Spring Semesters. Limited care is provided during the Winter Session. During the Summer, Health Services is open only for administrative issues.

To provide comprehensive care, Health Services works closely with the Babson Counseling Program and other departments.

For more information, call the Health Services at (781) 239-4257. In the event of an emergency, call Public Safety at extension #5555 or (781) 237-2828.

• Inpatient care is available by contract with Wellesley College for a student whose illness necessitates rest, nursing care, and medical monitoring, but does not require the full services of a hospital.

• The physician is on site in Health Services during regularly scheduled hours. Visits with the physician are by appointment only. Routine physical examinations are not provided.

• Counseling services are available through the Babson College program at Human Relation Services (HRS) in Wellesley for those students who want help adjusting to the college experience or are having emotional problems. The telephone number for HRS is (781) 235-4950 or call the Health Services at (781) 239-4257.

• Diagnostic X-rays, laboratory services, and medical specialists can be arranged through the Health Services after being evaluated by the Health Services staff.

• There is no charge to Babson College students for the following services rendered by the Health Services during clinic hours: services performed by a physician or nurse practitioner, nursing services, supplies, or non-prescription medications. A limited number of crutches, heating pads, ice packs, etc., are available for loan without charge.

• Services are provided to full-time, matriculating Babson College students only.

IMPORTANT NUMBERS

<table>
<thead>
<tr>
<th>Health Services</th>
<th>(781) 239-4257</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Safety</td>
<td>Extension #5555 or (781) 237-2828</td>
</tr>
</tbody>
</table>
BABSON COLLEGE STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefit available for Babson College students and their eligible dependents.

POLICY PERIOD

1. **MBA (Not One Year MBA) Students**: Coverage for all covered students enrolled for the Fall Semester will become effective at 12:01 a.m. on August 18, 2003, and will terminate at 12:01 a.m. on August 18, 2004.

2. **New Spring Semester MBA (Not One Year MBA) Students**: Coverage for all covered students enrolled for the Spring Semester will become effective at 12:01 a.m. on January 15, 2004, and will terminate at 12:01 a.m. on August 18, 2004.

3. **One Year MBA Students**: Coverage for all covered students enrolled for the One Year MBA Program will become effective at 12:01 a.m. on May 19, 2003, and will terminate at 12:01 a.m. on August 18, 2004.

4. **Covered Dependents**: Coverage will become effective on the same date the covered student's coverage becomes effective or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for covered dependents terminates in accordance with the Termination Provisions described in the Master Policy. Examples include, but are not limited to, the date the student's coverage terminates, and the last date of the period for which premium has been paid following the date the dependent no longer meets the definition of a dependent.

PREMIUM RATES

<table>
<thead>
<tr>
<th>MBA (Not One Year MBA) Students</th>
<th>Annual (8/18/03-8/18/04)</th>
<th>Spring Semester (1/15/04-8/18/04)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$948*</td>
<td>$618*</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,159</td>
<td>$1,426</td>
</tr>
<tr>
<td>Children</td>
<td>$1,550</td>
<td>$1,023</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>One Year MBA Students</th>
<th>Coverage Period 5/19/03 – 8/18/04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$1,277*</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,874</td>
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<tr>
<td>Children</td>
<td>$2,033</td>
</tr>
</tbody>
</table>

* An Administrative Cost is included in the Annual & Spring rates.

Premium for coverage must be received within the 31 day periods beginning with the start of the first and second semesters.
REFUND OF PREMIUM

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which the premium has been paid and no refund will be allowed. This applies to students on leave for medical or academic reasons and graduating students.

Covered Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person upon written request received by the Company within 90 days of withdrawal from school.

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest of one of the following: upon entry into the armed forces of any country; or; the end of the coverage period for which premium was paid; or; the date the Policy terminates. No benefits are payable after termination, except as stated in the Extension of Benefits provision.

A Covered Person’s coverage may be canceled, or its renewal refused, only in the following:

• Failure by the Covered Person or other responsible party to make payments under the Policy.
• Misrepresentation or fraud on the part of the Covered Person.
• Commission of acts of physical or verbal abuse by the Covered Person which pose a threat to providers or other insured(s) and which are unrelated to the Covered Person’s physical or mental condition.
• Relocation of the Covered Person outside the Policy’s service area.
• Non-renewal or cancellation of the Policy through which the Covered Person receives coverage or the Covered Person is no longer a student or Dependent.

No Covered Persons were involuntarily disenrolled within the past 2 years.

STUDENT COVERAGE

Eligibility: All full-time and qualifying part-time MBA Students enrolled for 9 or more credits are eligible for coverage.

WAIVER/ENROLLMENT PROCESS

All eligible students must complete an enrollment/waiver form by logging onto [www.universityhealthplans.com](http://www.universityhealthplans.com) by the specified deadline dates (see below). Eligible students will be automatically enrolled in the Policy unless the enrollment/waiver form has been submitted by the following deadline dates:

MBA (Not One Year MBA) Students

<table>
<thead>
<tr>
<th>Category</th>
<th>Waiver Deadline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returning Students</td>
<td>April 28, 2003</td>
</tr>
<tr>
<td>New Fall 03 Students</td>
<td>August 4, 2003</td>
</tr>
<tr>
<td>New Fall 03 Evening Students</td>
<td>September 18, 2003</td>
</tr>
<tr>
<td>New Spring 04 Students</td>
<td>January 2, 2004</td>
</tr>
<tr>
<td>New Spring 04 Evening Students</td>
<td>February 6, 2004</td>
</tr>
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</table>

One Year MBA Students

<table>
<thead>
<tr>
<th>Category</th>
<th>Waiver Deadline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Year MBA Students</td>
<td>May 16, 2003</td>
</tr>
</tbody>
</table>
DEPENDENT COVERAGE

Covered students may also enroll their lawful spouse and unmarried dependent children under age 19 who reside with, and are fully supported by, the covered student for the same coverage. Dependent enrollment can be completed online at [www.universityhealthplans.com](http://www.universityhealthplans.com).

MBA (Not One Year MBA) Students:
- The Fall enrollment deadline for dependents is September 28, 2003.
- The Spring enrollment deadline for dependents is January 15, 2004.

One Year MBA Students:
- The enrollment deadline for dependents is June 19, 2003.

A Dependent newborn child will be automatically covered under the Policy from the moment of birth until the 31st day following birth. During the 31 day period, we must receive written notice of the birth and the required premium must be paid.

Coverage for newly born infants and adoptive children shall consist of Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or premature birth including the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by the regulations of the department of public health.

For information or general questions on dependent enrollment, contact University Health Plans, Inc. at (800) 437-6448. To enroll please visit [www.universityhealthplans.com](http://www.universityhealthplans.com).

PREFERRED PROVIDER NETWORK

Students have access to the HealthCare Value Management (HCVM) Preferred Provider Network. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. A complete listing of preferred providers is available at the Babson College Health Services or by logging to [www.universityhealthplans.com](http://www.universityhealthplans.com).

If a Preferred Provider is not available in a particular area or specialty, the Policy will cover at the Preferred Provider level until a provider has been added.

Coverage will be provided at the Preferred Provider level for a provider who is not a Preferred Provider for the 30 days from the effective date of coverage if a Covered Person is undergoing an ongoing course of treatment or the provider is the Covered Person's primary care provider.

If the Covered Person is a female who is in her 2nd or 3rd trimester of pregnancy and whose provider in connection with her pregnancy is involuntary disenrolled, other than disenrollment for quality-related reasons or fraud, treatment will be allowed with said provider, according to the terms of the Policy, for the period up to and including the Covered Person’s first postpartum visit.

If a Covered Person is terminally ill and the provider in connection with said Sickness is involuntarily disenrolled, other than for quality related reasons or fraud, the Covered Person will be allowed to continue treatment with said provider, according to the terms of the Policy, until death of the Covered Person.

Continued coverage is conditioned upon the provider agreeing 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 the Covered Person in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; and
- Adhere to the Policy’s quality assurance standards and to provide necessary medical information related to the care provided; and
- Adhere to Our policies and procedures.

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

We will provide coverage for pediatric specialty care to Covered Persons requiring such services, including mental health services, by a person with recognized expertise in specialty pediatrics.
DEFINITIONS

**Accident** means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while a Covered Person is insured under the Policy.

**Biologically-Based Mental Disorders** means those disorders described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, referred to as “the DSM”: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, and 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.

**Co-payment** means a separate charge for certain Covered Medical Expenses which is paid by the Covered Person.

**Covered Medical Expense** means the Reasonable and Customary Charge (or Negotiate Fee) for a service or supply, which is performed or given under the direction of a Doctor for the treatment of Injury or Sickness pursuant to the terms of the Policy.

**Covered Person** means You or a Dependent insured under the Policy.

**Creditable Coverage** means: any blanket or general policy of medical, surgical or health insurance, including the Policy; any policy of accident or sickness insurance that provides hospital or surgical expense coverage; any non-group or group hospital or medical service plan issued by a non-profit hospital or medical corporation; any non-group health maintenance contract issued by a health maintenance organization; any self-insured or self-funded employer group health plan; any health coverage provided to persons serving in the Armed Forces of the United States; or Medicare or Medicaid.

**Dependent** means a person who resides with You and is Your, Legal spouse; Unmarried child(ren) under age 19 who are/is financially dependent on You. The term child includes a stepchild, a foster child, an adopted child and a child legally placed with You, who is a prospective adoptive parent, even if the adoption has not been finalized; and Child, despite attaining age 19, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and dependent on You for financial support.

**Doctor** means a licensed practitioner of the healing arts acting within the scope of his or her license. The Doctor may not be a member of the Covered Person’s immediate family. Doctor includes physician assistants, podiatrists, chiropractors, certified registered nurse anesthetist, nurse practitioner and certified nurse midwife.

**Emergency Medical Condition** 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 a Covered 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, serious jeopardy to the fetus.

A Covered Person has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever a Covered Person is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services. No Covered Person shall in any way be discouraged from using the local pre-hospital emergency medical services system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition.

**Experimental/Investigative:** Will not be considered experimental/investigative if successfully completed Stage III clinical trials of the United States Food and Drug Administration.

**HCVM Preferred Provider** means a provider in the HealthCare Value Management (HCVM) Preferred Provider Network.

**Home Health Care means:** Part-time nursing care, by or supervised by, a registered graduate nurse; part-time home health aide service which consists mainly of caring for the patient; physical, occupational, respiratory or speech therapy; nutrition counseling; medical social services by a qualified social worker licensed by the jurisdiction where services are rendered; medical supplies, prosthetic and orthopedic appliances, rental or purchase of durable medical equipment, drugs and medicines obtainable by prescription only, including insulin, but only to the extent that such charges would have been considered covered expenses had the Covered Person required confinement in a hospital or in a skilled nursing facility.

**Hospice Care means:** Doctor services; Nursing care provided by or under the supervision of a registered professional nurse; Social services; Volunteer services; and Counseling services provided by a professional or volunteer staff under professional supervision.

**Injury** means bodily harm caused by an Accident, which results in loss. All Injuries sustained in one Accident, including
Policy. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of Sickness (Sick) means either Biologically-Based Mental Disorders; rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape; a Non-Biologically Based Mental, Behavioral or Emotional Disorder of a Child or Adolescent Under the Age of 19; any biologically based mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association that are scientifically recognized and approved by the Commissioner of the Department of Mental Health (DMH) in consultation with the Commissioner of the Division of Insurance (DOI); or all other mental disorders described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Negotiated Fee means the fee the Participating Provider has agreed to for services or supplies under the plan. Non-Biologically-Based Mental, Behavioral or Emotional Disorders of a Child or Adolescent Under the Age of 19 means a disorder described in the most recent edition of the DSM which substantially interfere with or substantially limit the functioning and social interactions of such a child 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 Doctor, primary pediatrician, or a Licensed Mental Health Professional of such a child or adolescent or is evidenced by conduct, including, but not 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 disorder, or (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. The Policy shall continue to provide such coverage to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's 19th birthday until said course of treatment, as specified in said adolescent's treatment plan, is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

Pre-existing Condition means (1) a condition that manifested itself during the 6 months immediately preceding the Covered Person's effective date of coverage in such a manner as would have caused 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; (2) a pregnancy existing on the Covered Person's effective date of coverage.

Preventive Care Services means services rendered to a Dependent child from the date of birth through the attainment of six years of age and 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 Doctor.

Reasonable and Customary Charge (R&C) means the normal and customary charge of the provider, incurred by the Covered Person, in the absence of insurance for a service or supply, but not more than the prevailing charge in the area. Sickness (Sick) means illness or disease which begins or for which expense is incurred while coverage is in force under the Policy. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of a Sickness will be considered one Sickness.


DESCRIPTION OF BENEFITS
The Policy will pay 80%, except as specifically stated, of Covered Medical Expenses incurred by a Covered Person due to a covered Sickness or covered Injury, up to a maximum benefit of $100,000 per Sickness or Injury. Covered Medical Expenses for Pre-Existing Conditions are covered up to an outpatient maximum of $5,000 for Dependents. Covered Medical Expenses for an insured student are covered to an aggregate of $10,000, limited to $5,000 for outpatient treatment. Reimbursement is based on the Negotiated Fee for Preferred Providers or Reasonable and Customary based in accordance with data provided by Ingenix for out-of-network providers. Payments made to out-of-network providers shall be a percentage of the provider’s fees, up to Reasonable and Customary Charge, and not a percentage of the amount paid to Preferred Providers. Covered Medical Expenses are:

Hospital Room and Board: Hospital room and board and general nursing care while hospital confined, up to the semi-private room charge or the intensive care unit charge, if appropriate.
In-Network: 100% for the first 5 days then 80% thereafter.
Out-of Network: 100% for the first 5 days then 80% thereafter.
Miscellaneous Hospital Expense: 100% up to $1,000 then 80% thereafter for miscellaneous hospital charges incurred while hospital confined, including expenses for: anesthesia; operating room; laboratory tests; x-rays; oxygen tent; pre-admission tests; medicines or supplies; dressings; other non-room and board expenses; prescription drugs (excluding take-home drugs).

In-Hospital Doctor’s Expense: Services of a Doctor during hospital confinement, limited to one visit per day. This benefit does not apply when related to surgery.

Ambulance Expense: 100% for use of an ambulance for an Emergency Medical Condition to or from the hospital up to a maximum of $250.

Surgical Expense: Doctor’s fee for surgery.

Anesthesia Expense: Services of an anesthetist who is not employed or retained by the hospital in which the surgery is performed, up to 80% of the amount paid the surgeon.

Assistant Surgeon’s Expense: Service of an assistant surgeon required by the hospital, or by the procedure, up to 80% of the amount paid the surgeon.

Outpatient Miscellaneous Expense: Expenses incurred for outpatient services provided in a Doctor's office Licensed Mental Health Professional's office, a community mental health center, home bases services for Mental Illness, including hospital or outpatient department or emergency room, clinical lab, radiological facility or similar facility licensed by the state, up to a maximum benefit of $5,000 for each Sickness or Injury subject to the following per visit co-payment:

- **Emergency Room, not resulting in a hospital admission** – 80% of the Negotiated Charge (Preferred Provider) or 80% of Reasonable and Customary (out-of-network)
- **Doctor’s Office Visit**
  - Preferred Provider: 100% of the Negotiated Charge after a $10 co-payment per visit.
  - Out-of-Network: 80% of the Reasonable and Customary Charge after a $20 co-payment per visit.

Laboratory and X-Ray Expense: If referred by the College Health Services, Covered Medical Expenses are payable at 100% up to $250 per Sickness or Injury. Thereafter, benefits are payable at 80%. If not referred, Covered Medical Expenses will be paid at 80%.

Chiropractic/Physical Therapy Expense: Covered Medical Expenses will be paid as detailed under the Outpatient Miscellaneous Expense benefit of this Brochure.

Dental Expense: Treatment for Injury to sound natural teeth will be paid at 100% up to $500 per Accident. Removal of Impacted Wisdom Teeth is payable up to $100 per tooth.

Voluntary Termination of Pregnancy: Benefits will be paid the same as any other Sickness when a pregnancy had its inception during the term insured and is voluntarily terminated. These expenses must be incurred while the coverage is in force for the Covered Person.

PRESCRIPTION DRUG BENEFIT

After a Co-payment of $10 for generic or $20 for a brand name drug (per prescription), the cost of prescription drugs is payable in full, up to $1,000 for the Policy year, including hormone replacement therapy and contraceptive outpatient prescription drugs or devices approved by the U.S. Food and Drug Administration. Prescriptions must be filled at an "Express Scripts" Participating Pharmacy.

Coverage for a prescription drug will not be excluded for the treatment of cancer or HIV/AIDS on the grounds that the drug has not been approved by the U.S. Food and Drug Administration (FDA) for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia, in medical literature, or by the commissioner under the provisions of section forty-seven L. Prescription Drug coverage shall also include Medically Necessary services associated with the administration of the drug.) are covered and included in the $1,000 policy year maximum.

Covered Persons will be given an ID card to show the Pharmacy as proof of coverage. No claim forms need be completed once you receive this ID card. Until such card is received, you may fill prescriptions and be reimbursed by submitting a completed "Express Scripts" claim form. Claim forms can be obtained by calling Consolidated Health Plans at (800) 633-7867 or visiting their website at [www.consolidatedhealthplan.com](http://www.consolidatedhealthplan.com). A directory of participating pharmacies is available at the Health Services, by call Express Scripts directly at (800) 451-6245 or by logging onto [www.universityhealthplans.com](http://www.universityhealthplans.com).

NOTE: Not all medications are payable. Medications not covered by this benefit include, but are not limited to, allergy serum, drugs whose sole purpose is to promote or stimulate hair growth (Rogaine, Propecia, Renova), appetite
suppressants and smoking deterrents. A complete list of exclusions may be obtained by calling Express Scripts directly at (800) 451-6245.

STATE MANDATED BENEFITS

**Mental or Nervous Disorders Expense:** Mental Illness treatment for Biologically-Based Mental Disorders; rape-related mental disorders; and Non-Biologically Based Mental, Behavioral or Emotional Disorders of Children and Adolescents Under the Age of 19 will be paid the same as any other Sickness, except the diagnosis and treatment of rape-related mental or emotional disorders will be paid only if the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims. Treatment will consist of inpatient; intermediate and outpatient services that permit active and noncustodial treatment to take place in the least restrictive clinically appropriate setting.

**Mental Illness treatment** of all other mental disorders, which are described in the most recent edition of DMS, consisting of inpatient, intermediate and outpatient services that permit active and noncustodial treatment to take place in the least restrictive clinically appropriate setting. Treatment is limited during each 12-month period for a minimum of 60 days inpatient and 24 outpatient visits.

**Psychopharmacological services and neuropsychological assessment services expense.**

**Alcoholism and Chemical Dependency Expense: Inpatient:** Payment will be made the same as any other Sickness for confinement in an accredited or licensed hospital or in any other public or private facility providing services especially for the detoxification or rehabilitation and which is licensed by the department of public health, or in a residential alcohol treatment program, up to 60 days in any calendar year.

**Outpatient:** Payment will be made the same as any other Sickness up to a maximum of $5,000 per Policy Year. Outpatient services must be furnished by an accredited or licensed hospital or by any public or private facility or portion thereof providing services especially for the rehabilitation of intoxicated persons or alcoholics.

The limitation on benefits for treatment of alcoholism and chemical dependency shall not apply when said treatment is rendered in conjunction with treatment of mental or nervous disorders.

**Cytological Screening and Mammography Expense:** Benefits will be provided for: One annual cytological (pap smear) screening for ages 18 and over including chlamydia screening. A baseline mammogram for ages 35 through 39; A mammogram every year for women age 40 and over.

**Maternity Expense:** If a Covered Person or Dependent spouse is pregnant, We will pay for any expense incurred including expenses for prenatal care, childbirth and post-partum care (including well baby care on the same basis as any other Sickness). Expenses for childbirth include hospital inpatient care of not less than 48 hours following a vaginal delivery or not less than 96 hours following a cesarean section, unless the attending physician, in consultation with the mother, makes a decision for an earlier discharge from the hospital. The Covered Person is entitled to one home visit should they elect to participate in an early discharge.

**Preventive and Primary Care Expense for Children:** We will pay the expense for Preventive Care Services expenses actually incurred. These are for services rendered to a dependent child of a Covered Person from the date of birth through six years of age.

**Home Health Care Services**

**Hospice Care Benefits:** Eligible Expenses made by a licensed hospice care agency for inpatient services will be covered on the same basis as any inpatient expense. Services furnished to a Covered Person at home, on an outpatient basis, will be covered on the same basis as any outpatient expense.

**Early Intervention Services Expense:** We will pay 80% of the expense actually incurred up to a maximum of $3,200 per Policy year and an aggregate $9,600 over the total enrollment for Early Intervention Services. These services include occupational, physical and speech therapy, nursing care and psychological counseling. Expenses are payable for a dependent child of an Insured Person from birth until the child’s third birthday.

**Cardiac Rehabilitation Expenses:** Covered Medical Expenses are payable on the same basis as any other Sickness for the expense of Cardiac Rehabilitation if a Covered Person has a documented cardiovascular disease. We will pay for multidisciplinary treatment provided in either a Hospital or other setting. The treatment must meet standards promulgated by the Commissioner of Public Health. These standards include, but are not limited to, the requirement
that Outpatient treatment be initiated within 26 weeks after the diagnosis of the disease.

**Bone Marrow Transplants for the Treatment of Breast Cancer:** If a Covered Person has “metastatic” breast cancer, Covered Medical Expenses are payable as any other Sickness for the expense of a bone marrow transplant for the treatment of breast cancer. If a bone marrow transplant is not available from a Preferred Provider, benefits will be paid at the preferred level for such covered services rendered by a non-preferred provider.

**Scalp Hair Prosthesis Expense:** For prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, payable up to $350 per policy year.

**Non-prescription Enteral Formulas Expense:** We will pay up to $2,500.00 per Policy year for benefits for non-prescription enteral formulas (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.

**Infertility Expense:** Diagnosis and Treatment of Infertility, payable the same as any other Sickness. Infertility is a condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year. Benefit includes expense incurred for the following non-experimental infertility procedure: artificial insemination; in vitro fertilization and embryo placement; gamete intra-fallopiantransfer; zygote intrafallopian transfer; Intracytoplasmic sperm injection for the treatment of male factor infertility; and 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. Coverage is not limited to sperm provided by the Covered Person's spouse.

**Diabetes Diagnosis and Treatment Expense:** For treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. Benefit includes expense for blood glucose monitors; blood glucose monitoring strips for home use; voice-synthesizers for blood glucose monitors for use by the legally blind'; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; insulin pumps and insulin pump supplies; insulin pens, so-called; therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthist, prosthetist; supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy. Please note: insulin, syringes, and diabetic testing supplies are covered under the Prescription Drug portion of the Policy.

**High Cost Procedure Expense:** Covered Medical Expenses for high cost procedures in excess of $200, such as, but not limited to, outpatient diagnostic C.A.T. Scans, Magnetic Resonance Imaging, and Laser treatments are payable up to a maximum of $2,000 per Injury or Sickness.

**Reconstructive surgery following mastectomy:** Covered on the same basis as any other Sickness.

**Speech, hearing and language disorders:** Diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists for services are provided in a hospital, clinic or private office. Treatment in a school-based setting is not covered.

**Emergency Services Expense:** For health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for stabilization of an Emergency Medical Condition. If a Covered Person receives emergency services and cannot reasonable reach a Preferred Provider, payment for emergency services will be at the same level and in the same manner as if the person had received treatment by a preferred provider.

**Hormone Replacement Therapy:** for pre- and post-menopausal women.

**Outpatient Contraceptive Services:** including consultations, examinations, procedures and medical services related to contraceptive methods to prevent pregnancy approved by the U.S. Food and Drug Administration under the same terms and conditions for other outpatient services

**Cancer Clinical Trials:** for Qualified Cancer Clinical Trials as defined in MA Chapter 257 subject to all other terms and conditions of the policy.

**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, regulation and criteria established by the department of public health.
**Special Medical formulas**: for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic academia, or methylmalonic academia in infants and children or to protect the unborn fetuses of pregnancy women with phenylketonuria.

**SUPPLEMENTAL MEDICAL COVERAGE**

The Aggregate Maximum benefit under the Student Accident and Sickness Insurance is $100,000. If you have purchased the Basic Student Health Insurance Plan at Babson College, you are eligible to purchase this Supplemental Plan to extend the combined maximum to $250,000 for students and $100,000 for dependents.

**EXTENSION OF BENEFITS AFTER TERMINATION**

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

The total payments made in respect of the Covered Person for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this Extension of Benefits After Termination provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

**CONTINUOUSLY INSURED**

Any Covered Person who has continuous coverage under this Plan and the prior plan shall be covered for conditions first manifesting themselves while continuously insured, except for benefits payable under prior policies in the absence of this Plan. Prior plan means the Student Health Insurance Policy issued to the Policyholder immediately before this Policy or any other Creditable Coverage, as defined.

**SUBROGATION**

If claims for an Injury or Sickness are incurred by an Insured Person, and it appears that the Injury or Sickness was due to the fault of someone else, the Plan will not pay for such claims until it has obtained documentation from the Insured Person establishing its reimbursement rights in accordance with the Plan.

**LIMITATIONS**

**Excess Coverage:**

Benefits in excess of $250 are payable only on an excess basis over and above any covered provided by any other group, blanket, franchise or pre-paid service policy or plan, regardless of any Coordination of Benefits, non-duplication of benefits, or any similar provisions contained in such policies or plans.

**Pre-Existing Conditions Limitation:**

Pre-existing Conditions are not covered for the first 6 months following the Covered Person’s effective date of coverage under the Policy. This limitation will not apply if, during the period immediately preceding the Covered Person’s effective date of coverage under the Policy, the Covered Person was covered under prior Creditable Coverage for 6 consecutive months. Prior Creditable Coverage of less than 6 months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Conditions will apply only if the Covered Person becomes eligible and applies for coverage within 63 days of termination of her or her prior coverage. The Covered Person must provide us proof of prior Creditable Coverage.

You must contact the administrator of Your prior Creditable Coverage and secure and submit to us a Certificate of Coverage in order for Consolidated Health Plans to allow the credit.

The time for which You are covered under this plan may be eligible for credit toward satisfaction in a Plan under which You subsequently become covered. When Your coverage terminates under this plan, Consolidated Health Plans will, at Your request, issue a Certificate of Coverage to You for that purpose.
EXCLUSIONS

The policy does not cover Loss nor provide benefits for:

1. Expenses for daily hospital room and board higher than the usual semi-private room charge or higher than the usual charge for the Intensive Care Unit, if applicable.
2. Expenses incurred for medical services, treatments and supplies for which no charge would have been normally made in the absence of insurance.
3. Services normally provided without charge by your Health Services, Infirmary or Hospital or any employees thereof.
4. Surgery for the correction of refractive error and services in connection with eye examinations, eye glasses or contact lenses or hearing aids, except as required for a repair due to an Accident in which the Covered Person sustains an Injury.
5. Loss resulting from participation in an illegal occupation, riot, civil commotion or act of terrorism; or committing, or attempting to commit, a felony.
6. Elective plastic or cosmetic surgery, unless resulting directly from an Injury which necessitated medical treatment within 24 hours of the Accident. This exclusion does not apply to cosmetic surgery made necessary by an Injury or a congenital disease or deformity of a newborn child who is a Dependent insured under the Policy.
7. Loss resulting from air travel, except as a fare-paying passenger on a commercial airline.
8. Injury sustained or Sickness contracted while in the armed forces of any country.
9. An occupational loss covered by any occupational benefit plan, Workers’ Compensation Act or similar law.
10. Treatment, services or supplies received in a governmental hospital unless the Covered Person is legally obligated to pay such charges in the absence of insurance.
11. Expense incurred for treatment of injuries resulting from any motor vehicle accident to the extent covered by other valid and collectible insurance, or third party action.
12. Expenses, which are reimbursable by any other valid and collectible hospital or insurance plan in excess of $250, but such charges in excess thereof shall be covered as otherwise provided.
13. Expenses for Prescription Drugs, except as specifically provided in The Policy.
14. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extractions of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia. This exclusion does not apply to the repairs to sound natural teeth caused by an Injury. This exclusion does not apply to the removal of impacted wisdom teeth.
15. Expense incurred after coverage terminates except as may be specifically provided in the Extension of Benefits Provision.
16. Elective treatment or elective surgery, except as specifically provided.
17. Routine physicals, preventive medicines, serums, or vaccines.
18. Injury resulting from the play or practice of intercollegiate sports, including intercollegiate club and intramural sports in excess of $1,500.

Traveler’s Assistance Services

This benefit is underwritten by UNUM and is designed to protect Babson College students who are traveling more than 100 miles from their permanent residence. The benefit includes a medical assistance program designed to access medical care providers and provide medical evacuation and repatriation to the Insured Person’s home country. Benefits include: Air evacuation of the covered person includes an accompanying physician and nurse, to the nearest facility capable of providing proper care. Repatriation and medical evacuation are subject to the same exclusions that exist in the student health insurance policy issued to Babson College. A toll free telephone number will be printed on your ID card for access to Traveler’s Assistance Services.

CLAIMS PROCEDURES

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim from is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to Consolidated Health Plans.

Within 45 days following receipt of the appropriate documentation, we will either (1) make payment for the services provided, (2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or (3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If we fail to comply, We are required to pay, in addition to any reimbursement for health care services provided,
interest on the benefits beginning 45 days after receipt of the properly documented claim at the rate of 1.5 percent per month, not to exceed 18 percent per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

There is no utilization review performed on this policy.

CLAIM APPEAL

To appeal a claim, send a letter stating the issues of the appeal to Consolidated Health Plan’s Appeal Department at the above address. Include your name, phone number, address, school attended and email address, if available. Claims will be reviewed and responded to within 60 days by Consolidated Health Plans.

Translation services are available to assist insured(s), upon request, related to administrative services.

This Brochure is a brief description of the Plan Benefits. The exact provisions governing the insurance are contained in the Policy issued to Babson College located in Health Services.

Any provision of the Policy or this brochure which is in conflict with the statutes of the state in which the Policy is issued, will be administered to conform with the mandates of the state.

The Plan is Underwritten By:
Guarantee Trust Life Insurance Company
Policy Number: 204-163-001R

Claims Administrator:
Consolidated Health Plans
195 Stafford Street
Springfield, MA 01104-3503
(800) 633-7867

www.consolidatedhealthplan.com

Please visit our website to check claims status and eligibility

Servicing Broker:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
Local: (617) 472-5324
Out of area: (800) 437-6448

www.universityhealthplans.com

Please visit our website for frequently asked questions and answers regarding this plan, or email us at info@univhealthplans.com

The Plan is underwritten by Guarantee Trust Life Insurance Company. The exact provisions governing the insurance are contained in the Master Policy issued to the College, and may be viewed at the College’s Health Services during normal business hours. Any discrepancy between this brochure and the Master Policy will be governed by the Master Policy. The plan is managed by University Health Plans, Inc., One Batterymarch Park, Quincy, MA 02169-7454.
VISION BENEFITS

The Vision One discount program is available to participants in the Student Health Insurance Plan through Cole Vision® at no additional cost. This program may help you save on many eye care products, including eyeglasses and contact lenses, nonprescription sunglasses, contact lens solutions and accessories.

The Vision One program is available at many optical centers nationwide – such as Sears, JCPenney, Target, most Pearle Vision Centers and others – as well as through selected independent optometrist and ophthalmologist offices.

When you visit a Vision One location, show your Student Health Insurance card, and any applicable services or merchandise you receive will be discounted right at the point of purchase. There are no claim forms to complete and no waiting for reimbursement.

Here is an example of some of the discounts you are eligible for:

<table>
<thead>
<tr>
<th>Frames</th>
<th>Vision One Cost</th>
<th>Typical Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to $60 retail</td>
<td>$25</td>
<td>58%</td>
</tr>
<tr>
<td>$60 to $80 retail</td>
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<tr>
<td>$80 to $100 retail</td>
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</tr>
<tr>
<td>Over $100 retail</td>
<td></td>
<td>35% off retail</td>
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<tr>
<td>Exams – Spectacle</td>
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<td>$5 discount</td>
</tr>
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<table>
<thead>
<tr>
<th>Lenses</th>
<th>Additional</th>
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<tbody>
<tr>
<td>Single Vision</td>
<td>$30</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$50</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$60</td>
</tr>
<tr>
<td>Lens Options</td>
<td></td>
</tr>
<tr>
<td>Standard Progressive (no-line bifocal)</td>
<td>$50</td>
</tr>
<tr>
<td>Polycarbonate</td>
<td>$30</td>
</tr>
<tr>
<td>Scratch Resistant Coating</td>
<td>$12</td>
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<tr>
<td>Ultraviolet Coating</td>
<td>$12</td>
</tr>
<tr>
<td>Anti-Reflective Coating</td>
<td>$35</td>
</tr>
<tr>
<td>Photochromic</td>
<td>$30</td>
</tr>
<tr>
<td>Solid or Gradient Tint</td>
<td>$8</td>
</tr>
</tbody>
</table>

| Contact Lenses                  |                 |
| Non-Disposable Contacts         |                 | 20%             |
| Disposable Contacts             |                 | 10%             |
| Exams – Contacts                |                 | $10 discount    |

To find the nearest Vision One location log on to the Cole Managed Vision website at www.cmvc.com or call 1-800-424-1155, weekdays from 9 a.m. to 9 p.m. ET and Saturdays from 9 a.m. to 5 p.m. ET to speak to a representative. Cole Managed Vision Plan #47034.