2007-2008

Student Health Insurance Plan

Offered by:
Chickering Benefit Planning Insurance Agency, Inc.
Administered by:
Chickering Claims Administrators, Inc.
Underwritten by:
Aetna Insurance Company of Connecticut (AICC)

Policy No. 890428
Dear Students and Parents:

The Student Health Insurance Plan for Bentley students, underwritten by Aetna Life Insurance Company, will be effective on **August 15, 2007**.

We believe that the Student Health Insurance Plan will provide reasonable protection against illnesses and accidents at a cost low enough so as not to constitute an undue burden. The Massachusetts Universal Health Care Act mandates that all students enrolled three-quarter time to full time in a degree-granting program at all colleges and universities in Massachusetts participate in a qualifying health insurance program.

Therefore, if you do not have health insurance provided by a U.S.-based carrier, you are required to participate in the Student Health Insurance Plan offered through Bentley. This state mandate applies to all undergraduate students who are registered for 9 or more credit hours, graduate students who are registered for 6.75 or more credit hours each semester and all full time PhD students. The fee for the Student Health Insurance offered through Bentley is $995 for full-year coverage and $581 for spring semester only.

All students must annually submit a waiver form if they have health insurance provided by a U.S.-based carrier by logging onto [www.chickering.com](http://www.chickering.com). Click on “Find Your School” and type in Bentley.

Once on Bentley’s page, click on Enroll/Waive. This will bring you to the page where you may Enroll or Waive the Student Health Insurance plan offered through Bentley. **International students are not eligible to waive participation in the Insurance Plan online. If you are covered under a U.S. based health insurance company, please contact Student Financial Services at 781-891-2162 for further instructions.**

The deadline for completing a waiver is **August 1, 2007**, for Fall 2007 students and **January 3, 2008**, for all Spring 2008 students.

This brochure has been prepared to provide a description of the Student Health Insurance Plan offered by Bentley.

Sincerely,

Gerri Taylor, MS, APRN, BC  
Assistant Dean for Health and Prevention  
Director of Student Health Services  
Adult Nurse Practitioner
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THIS SUMMARY OF COVERAGE IS NOT MEDICARE SUPPLEMENT COVERAGE.
If you are eligible for Medicare, review the Medicare Supplement Buyer’s Guide available from
the plan administrator.
The Student Health Insurance Plan provided through Bentley has been developed especially for Bentley 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. Bentley is pleased to offer the Plan as described in this Brochure.

Where To Find Help

Got Questions? Get Answers with Chickering’s Aetna Navigator™
As a Chickering student health insurance member, you have access to Aetna Navigator, your secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online. By logging into Aetna Navigator, you can:
• Review who is covered under your plan.
• Request member ID cards.
• View Claim Explanation of Benefits (EOB) statements.
• Estimate the cost of common health care services and procedures to better plan your expenses.
• Research the price of a drug and learn if there are alternatives.
• Find health care professionals and facilities that participate in your plan.
• Send an e-mail to Chickering Customer Service at your convenience.
• View the latest health information and news, and more!

How do I register?
• Go to www.chickering.com.
• Click on “Find Your School.”
• Enter your school name and then click on “Search.”
• Click on Aetna Navigator and then the “Access Navigator” link.
• Follow the instructions for First Time User by clicking on the “Register Now” link.
• Select a user name, password and security phrase.
Your registration is now complete, and you can begin accessing your personalized information!

Need Help With Registering onto Aetna Navigator?
Registration assistance is available toll-free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at 1-800-225-3375.

For Questions About:
• Insurance Benefits
• System – issues regarding the Enrollment/Waiver process
• Claims Processing
• Inpatient Admission Pre-Certification

Please contact:
Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 481-8814
www.chickering.com
For Questions About:
• Enrollment Forms
• Waiver Process
• Health Insurance Charges
Please contact:
  Student Financial Services at Bentley
  (781) 891-2162

For Questions About:
• Insurance Benefits
• Insurance Claims or Bills
• Statements of Benefits
Please contact:
  Cynthia Cunha, Student Health Insurance Coordinator at Student Health Services, Bentley.
  781-891-2600

For Questions About:
• ID Cards
ID cards will be issued as soon as possible. If you must seek medical attention before the permanent ID card is received, benefits will be payable in accordance with the Policy. **You do not need an ID card to be eligible to receive benefits.** Once you have received your permanent ID Card, present it to the provider to facilitate prompt payment of your claims.
Note: Please be advised you will receive a unique Aetna member ID number on your membership card.

For lost ID Cards, please contact: Chickering Claims Administrators, Inc.
  (800) 481-8814 or visit www.chickering.com click on “Find Your School” and enter 890428 as your Policy Number.

For Questions About:
• On Campus Student Health Services
Please contact:
  Bentley Student Health Services
  Rhodes Hall
  (781) 891-2222
  http://www.bentley.edu/health

For Questions About:
• Status of Pharmacy Claims
• Pharmacy Claim Forms
• Excluded Drugs and Pre-Authorization
Please contact:
  Aetna Pharmacy Management
  (800) 238-6279
For Provider Listings (Including Preferred Care Pharmacies):
A complete list of providers can be found by accessing www.chickering.com and using Aetna’s DocFind® Service.

For Worldwide Web Access:
- The Chickering Group
  www.chickering.com
- Worldwide Travel Assistance
  medservices@assistamerica.com

<table>
<thead>
<tr>
<th>Student Health Insurance Plan Offered Through Bentley</th>
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This is a brief description of the Accident and Sickness Medical Expense benefits available for Bentley students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to Bentley and may be viewed at the Office of the Administrative Coordinator for Student Health Insurance located at Student Health Services, Rhodes Hall during normal business hours. The Plan is administered by Chickering Claims Administrators, Inc., P.O. Box 15708, Boston, MA 02215-0014.

**Bentley Student Health Services**
Bentley Student Health Services is open Monday, Wednesday and Thursday from 8:00 a.m. to 5:00 p.m., Tuesday, 8:00 a.m. to 7:00 p.m. and Friday, 8:00 a.m. to 4:30 p.m. by appointment. There is no charge for care provided at Student Health Services. The cost is covered by tuition for all full-time graduate and undergraduate students REGARDLESS OF WHAT INSURANCE PLAN YOU HAVE AT BENTLEY. (YOU DO NOT HAVE TO HAVE THE INSURANCE PLAN OFFERED THROUGH BENTLEY IN ORDER TO COME TO STUDENT HEALTH SERVICES.) Please check our web page at http://ecampus.bentley.edu/dept/hlth or contact us by phone at (781) 891-2222.

All inquiries and services are strictly confidential.

**Policy Period**
1. **Annual:** Coverage for all newly insured and returning students enrolled for the Fall Semester will become effective at 12:01 a.m. on **August 15, 2007**, and will terminate at 12:01 a.m. on **August 15, 2008**.

2. **New Spring Semester Students:** Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a.m. on **January 15, 2008**, and will terminate at 12:01 a.m. on **August 15, 2008**.

3. **Insured Dependents:** Coverage will become effective on the same date the insured student’s coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured 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 date the dependent no longer meets the definition of a dependent.
### Premium Rates

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual</th>
<th>Spring Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$995</td>
<td>$581</td>
</tr>
<tr>
<td>Spouse Only</td>
<td>$2,007</td>
<td>$1,164</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$1,475</td>
<td>$855</td>
</tr>
</tbody>
</table>

### Premium Refund Policy

Except for medical withdrawal due to a covered Accident or Sickness, any student withdrawing from school during the first 36 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 36 days will remain covered under the Policy for the full period for which the premium has been paid. No refund will be allowed.

A Covered Person 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, and any covered dependents. Please contact: Student Financial Services at Bentley, (781) 891-2162.

### Student Coverage

**Eligibility**

All undergraduate students enrolled in 9 credits or more, graduate students enrolled in 6.75 credits or more each semester and full-time PhD students are required as mandated by Massachusetts State Law to have a U.S.-based health insurance plan while attending Bentley.

**Enrollment and Waiver Process/Procedure**

If students have a U.S-based health insurance plan, they can waive the Student Health Insurance Plan offered by Bentley by going to [www.chickering.com](http://www.chickering.com) by August 1, 2007. Otherwise, all undergraduate students enrolled in 9 credits or more, graduate students enrolled in 6.75 credits or more each semester and full-time PhD students MUST enroll on-line in the Student Health Insurance Plan offered through Bentley. International students are not eligible to waive participation in the Insurance Plan online. If you are covered under a U.S.-based insurance company, please contact Student Financial Services at Bentley (781) 891-2162.

Free Care is not a health insurance plan and therefore, does not constitute as a qualifying health insurance plan.

<table>
<thead>
<tr>
<th>Category</th>
<th>Waiver Deadline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students enrolling for the Fall Semester</td>
<td>August 1, 2007</td>
</tr>
<tr>
<td>Students enrolling for the Spring Semester</td>
<td>January 3, 2008</td>
</tr>
</tbody>
</table>

### Dependent Coverage

**Eligibility**

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. For further assistance and premium information, please contact The Chickering Group at (800) 481-8814.
Newborn Infant Coverage and Adopted Child Coverage
A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the Student Health Insurance Plan offered through Bentley. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional premium starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Person for 31 days from the moment of placement, provided the child lives in the household of the Covered Person and is dependent upon the Covered Person for support. To extend coverage for an adopted child past the 31 days, the Covered Person must (1) enroll the child within 31 days of placement of such child and (2) pay any additional premium, if necessary, starting from the date of placement.

Preferred Provider Network
The Chickering Group has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the Bentley campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of Bentley, Chickering Claims Administrators, Inc., or Aetna Life Insurance Company. A complete listing of Participating Providers is available by contacting Chickering Claims Administrators, Inc. at (800) 481-8814. Additionally, you can obtain information regarding Preferred Providers through the Internet by accessing DocFind at: www.chickering.com, click on “Find Your School” and enter 890428 as your Policy Number.

Referral Requirements
NO REFERRAL is required for off campus medical services and physician’s appointments. If you are enrolled in the Student Health Insurance Plan, it is to your advantage to first seek treatment at Bentley Student Health Services when the office is open, in order to reduce your out-of-pocket expenses. Please refer to the Summary of Benefits Chart for details.

Inpatient Admission Pre-Certification Program
Pre-admission certification is designed to help you receive quality, cost-effective medical care.
• All inpatient admissions, including length of stay, must be certified by contacting Chickering Claims Administrators, Inc.
• Pre-Certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Health Insurance Plan.
• If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a $200 per admission Deductible.


Pre-Certification of Non-Emergency Inpatient Admissions:
The patient, Physician, or hospital must telephone at least three business days prior to the planned admission.

Notification of Emergency Admissions
The patient, patient’s representative, Physician, or hospital must telephone within one business day following admission.

Chickering Claims Administrators, Inc.
P.O. Box 15708
Attention: Managed Care Dept.
Boston, MA 02215-0014
(800) 481-8814

Description of Benefits
Payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or any one Sickness while insured under the Plan, not to exceed $50,000 Policy Year maximum per Accident or Sickness.

In addition to the Plan's Aggregate Maximum the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this brochure for any additional benefit level maximums.

The payment of any Copays, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person. To maximize your savings and reduce out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Care is subject to the Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

A complete listing of Preferred Providers is available by contacting Chickering Claims Administrators, Inc. at (800) 481-8814 for specific provider information. You can also use the Internet and Aetna’s DocFind at: www.chickering.com, click on “Find Your School” and enter 890428 as your Policy Number.
The following benefits are subject to the imposition of Policy limits and exclusions. All coverage is based on Reasonable Charges unless otherwise specified.

<table>
<thead>
<tr>
<th>Inpatient Hospitalization Benefits</th>
<th>Covered Medical Expenses are payable as follows:</th>
</tr>
</thead>
</table>
| Hospital Room and Board Expenses  | **Preferred Care:** 80% of the Negotiated Charge.  
                                      **Non-Preferred Care:** 80% of the average semi-private room rate. |
| Intensive Care Unit Expenses       | **Preferred Care:** 80% of the Negotiated Charge.  
                                      **Non-Preferred Care:** 80% of the intensive care room rate. |
| Miscellaneous Hospital Expenses    | **Preferred Care:** 80% of the Negotiated Charge.  
                                      **Non-Preferred Care:** 80% of the Reasonable Charge.  
                                      Covered Medical Expenses include, but are not limited to, X-ray examination, laboratory tests, anesthesia, use of operating room, special equipment, and medicines. |
| Physician’s Hospital Visit Expenses| Covered Medical Expenses for the non-surgical services of the attending Physician or a consulting Physician are payable as follows:  
                                      **Preferred Care:** 80% of the Negotiated Charge.  
                                      **Non-Preferred Care:** 80% of the Reasonable Charge. |

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<tr>
<th>Surgical Benefits (Inpatient and Outpatient)</th>
<th>Covered Medical Expenses are payable as follows:</th>
</tr>
</thead>
</table>
| Surgical Expenses                           | **Preferred Care:** 80% of the Negotiated Charge.  
                                      **Non-Preferred Care:** 80% of the Reasonable Charge. |
| Anesthetist Expenses                        | **Preferred Care:** 80% of the Negotiated Charge.  
                                      **Non-Preferred Care:** 80% of the Reasonable Charge. |
| Assistant Surgeon Expenses                  | **Preferred Care:** 80% of the Negotiated Charge.  
                                      **Non-Preferred Care:** 80% of the Reasonable Charge. |

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<thead>
<tr>
<th>Outpatient Benefits</th>
<th>Covered Medical Expenses are payable as follows:</th>
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</thead>
</table>
| Outpatient Hospital Services Expenses      | **Preferred Care:** 80% of the Negotiated Charge.  
                                      **Non-Preferred Care:** 80% of the Reasonable Charge. |
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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</table>
| Physician’s Office Visits/Walk-In-Clinic Expenses | Covered Medical Expenses for the treatment of an accidental Injury or Sickness are payable as follows:  
**Preferred Care:** 100% of the Negotiated Charge after a $15 per visit Copay.  
**Non-Preferred Care:** 100% of the Reasonable Charge after a $25 per visit Deductible. |
| Emergency Room Expenses              | Covered Medical Expenses for the treatment of an accidental Injury or Sickness are payable as follows:  
**Preferred Care:** 80% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Reasonable Charge. |
| Laboratory and X-ray Expenses        | Covered Medical Expenses are payable as follows:  
**Preferred Care:** 80% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Reasonable Charge.  
**Please note:** when samples are taken or drawn at Bentley Student Health Services, lab services are payable at 100% of the Reasonable Charge. |
| Allergy Testing and Treatment Expense | Covered Medical Expenses are payable as follows:  
**Preferred Care:** 80% of the Negotiated Charge.  
**Non-Preferred Care:** 80% of the Reasonable Charge.  
Allergy serum is not covered. |
| **Mental Health and Substance Abuse Benefit** | Covered Medical Expenses for the treatment of a mental health condition or for substance abuse are payable as follows: Treatment of Biologically based mental health conditions, or rape related mental or emotional disorders, while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other inpatient expense. Covered Medical Expenses also include charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Chickering Claims Administrators, Inc. at (800) 481-8814.  
Treatment of Non-Biologically based mental health conditions, or for substance abuse, while confined as an inpatient in a hospital or facility for such treatment, are payable on the same basis as any other inpatient expense subject to a maximum of 60 days per Policy Year.  
Covered Medical Expenses also include charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Chickering Claims Administrators, Inc. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization. |
<table>
<thead>
<tr>
<th>Mental Health and Substance Abuse Benefits (continued)</th>
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<tbody>
<tr>
<td><strong>Outpatient Mental Health/Substance Abuse Expenses</strong></td>
</tr>
<tr>
<td>Covered Medical Expenses for the treatment of a mental health condition or for substance abuse are payable as follows: Treatment for Biologically based conditions or rape related mental or emotional disorders are covered on the same basis as any other outpatient expense. Treatments for Non-Biologically based mental health conditions, including substance abuse, are covered on the same basis as any other outpatient expense. Covered Medical Expenses are subject to a maximum of 24 visits for outpatient treatment.</td>
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<tr>
<th>Maternity Benefits</th>
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<tr>
<td><strong>Maternity Expenses</strong></td>
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<tr>
<td>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverage shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by the Department of Public Health. In such cases, Covered Medical Expenses may include home visits, parent education, and assistance and training in breast or bottle feeding.</td>
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<tr>
<th>Voluntary Termination of Pregnancy Expenses</th>
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<tr>
<td>Covered Medical Expenses for voluntary termination of pregnancy are payable on the same basis as any other Sickness.</td>
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<tr>
<th>Additional Benefits</th>
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<tr>
<td><strong>Prescription Contraceptive Medical Expenses</strong></td>
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<tr>
<td>Covered Medical Expenses are payable on the same basis as any other expense. Covered Medical Expenses also include any expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive. Coverage of oral contraceptives, Lunelle, Depo-Provera, Ortho Evra Patch and Nuva Ring, or generic equivalent when available, are provided under the separate Prescription Drug Benefit portion of the Plan.</td>
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<thead>
<tr>
<th>Prescription Drug Benefit Expenses</th>
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<tr>
<td>Covered Medical Expenses for outpatient Prescription drugs associated with a covered Sickness or covered Accident which occurs during the Policy Year are payable as follows with a $500 Policy Year Maximum. <strong>Preferred Care:</strong> 100% of the Negotiated Charge after a $10 Copay for each Generic Prescription Drug and a $15 Copay for each Brand-Name Prescription Drug. <strong>Non-Preferred Care:</strong> 100% of the Reasonable Charge after a $10 Deductible for each Generic Prescription Drug and a $15 Deductible for each Brand-Name Prescription Drug. Please note that you are required to pay in full at the time of service for all Prescriptions.</td>
</tr>
<tr>
<td><strong>Additional Benefits (continued)</strong></td>
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<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Prescription Drug Benefit Expenses</strong> (continued)</td>
</tr>
<tr>
<td><strong>Special Medical Formula Expense</strong></td>
</tr>
<tr>
<td><strong>Non Prescription Enteral Formula Expense Benefits</strong></td>
</tr>
<tr>
<td><strong>Ambulance Expenses</strong></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment Expenses</strong></td>
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<tr>
<td><strong>Dental Expenses</strong></td>
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## Additional Benefits (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
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</table>
| **Home Health Care Expenses**| Charges incurred within 12 months from the date of the first Home Health Care visit, will be covered up to a maximum of 40 visits. Four hours of home health aide service shall be considered as one Home Health Care visit. Covered Medical Expenses are payable as follows:  
*Preferred Care:* 80% of the Negotiated Charge.  
*Non-Preferred Care:* 80% of the Reasonable Charge. |
| **Hospice Care Expenses**    | Covered Medical Expenses for inpatient care will be covered on the same basis as any inpatient expense up to a lifetime maximum of 30 days.                                                                 |
| **Physical Therapy Expenses**| Covered Medical Expenses for physical therapy performed in an office are payable as follows:  
*Preferred Care:* 100% of the Negotiated Charge after a $10 Copay per visit.  
*Non-Preferred Care:* 100% of the Reasonable Charge after a $10 Deductible per visit. |
| **Chiropractic Expenses**    | Initial treatment must occur within three calendar days of an accident or the onset of the illness. Covered medical expenses in a doctor’s office or walk-in clinic are payable as follows:  
*Preferred Care:* 100% of the Negotiated Charge.  
*Non-Preferred Care:* 100% of Reasonable Charge.  
Medical care to diagnose or treat the Sickness or Injury, or follow-up care is payable as follows:  
*Preferred Care:* 100% of the Negotiated Charge after a $15 Copay per visit.  
*Non-Preferred Care:* 100% of Reasonable Charge after a $25 Deductible per visit. |
| **Nutritional Counseling Services Expenses** | Covered Medical Expenses for Nutritional Counseling is considered only when determined to be medically necessary for chronic disease states in which dietary adjustment has a therapeutic role. (e.g., cardiovascular disease, eating disorders, diabetes, hypertension, kidney disease, gastrointestinal disorders, seizures- ketogenic diet.) Covered persons are encouraged to seek initial treatment with Bentley Student Health Services or the Office of Counseling and Student Development. Benefits are payable as detailed under the Outpatient Benefits section of this Brochure. |
| **Routine Pediatric Care Expenses** | Covered Medical Expenses are payable as follows for services rendered in a Physician’s office:  
*Preferred Care:* 100% of the Negotiated Charge after a $10 per visit Copay.  
*Non-Preferred Care:* 100% of the Reasonable Charge after a $10 per visit Deductible. |
| Routine Pediatric Care Expenses (continued) | Covered Medical Expenses include the following services:  
• physical examination;  
• history;  
• measurements;  
• sensory screening;  
• neuropsychiatric evaluation; and,  
• development screening, and assessment at the following age intervals:  
  Birth to under age 1 (6 exams per year)  
  Age 1 to under age 2 (3 exams per year)  
  Age 2 to under age 6 (1 exam per year)  
Services shall include hereditary and metabolic screening at birth, appropriate immunizations and tuberculin tests, hematocrit, hemoglobin, or other appropriate blood tests and urinalysis as recommended by the Physician. |
| Early Intervention Services Expenses | Covered Medical Expenses for services for an early intervention provider for eligible dependent children as mandated by Massachusetts law are payable as follows:  
**Preferred Care:** 80% of the Negotiated Charge after a $35 per visit Copay.  
**Non-Preferred Care:** 80% of the Reasonable Charge after a $35 per visit Deductible.  
Benefits are provided up to $5,200 for each child per Policy Year, not to exceed $15,600 during the entire time the child is eligible for these benefits.  
Benefits are provided from birth until three months after the child reaches age three (or September 1 of the year of the child's third birthday if the child was born after April 1).  
Covered Medical Expenses include physical and occupational therapy, speech/language pathology services (speech therapy), nursing care, and psychological counseling. |
| Hearing Screening Expenses for Newborns | Hearing Screenings for newborns means services rendered to a dependent child of a Covered Person for hearing tests performed before the newborn infant is discharged from the hospital or birthing center. Covered Medical Expenses are payable at 80% of the Actual Charge. |
| Diabetic Equipment and Self-Management Expenses  
*(Please note: Insulin, syringes, and diabetic testing supplies are covered under the Prescription Drug portion of the Plan)* | Covered Medical Expenses for diabetic equipment, other than those provided under the Prescription Drug portion of the Plan, and Self-Education Program management education programs, are payable on the same basis as any expense. |
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<thead>
<tr>
<th>Additional Benefits (continued)</th>
<th>Description</th>
</tr>
</thead>
</table>
| **High Cost Procedure Expenses**                        | 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 as follows:  
  *Preferred Care:* 80% of the Negotiated Charge.  
  *Non-Preferred Care:* 80% of the Reasonable Charge.  
  Covered Medical Expenses are payable up to a maximum of $2,000 per Accident or Sickness.                                                                                   |
| **Cardiac Rehabilitation Expenses**                     | Covered Medical Expenses are payable on the same basis as any other Sickness for covered expenses incurred for cardiac rehabilitation treatment rendered in connection with documented cardiovascular disease. Treatment includes, but is not limited to, outpatient treatment which is initiated within 26 weeks after diagnosis of cardiac vascular disease. |
| **Bone Marrow Transplant Expenses for Breast Cancer**   | Covered Medical Expenses are payable on the same basis as any expense in accordance with State Law. Refer to the Master Policy for details.                                                                                                                                                                   |
| **Infertility Benefit Expenses**                         | Covered Medical Expenses are payable on the same basis as any expense for medically necessary expenses for the diagnosis and treatment of infertility. Covered Medical Expenses includes expenses incurred for non-experimental infertility procedures, including artificial insemination, in-vitro fertilization and embryo placement, gamete intrafallopian transfer, 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, intracytoplasmic sperm injection for treatment of male factor fertility, and zygote intrafallopian transfer. Benefits payable under this provision are not subject to any pre-existing conditions exclusion (if applicable under the Plan). |
| **Women’s Health Benefit Expenses**                     | Covered Medical Expenses include expenses for an annual Pap smear for women age 18 and older. Covered Medical Expenses are payable on the same basis as any outpatient expense. If follow-up diagnostic Pap smears are Medically Necessary, they will be covered on the same basis as any outpatient expense. Covered Medical Expenses include one baseline mammogram for women between the ages of 35 and 39. Women age 40 and over have coverage for one annual mammogram per Policy Year thereafter. Covered Medical Expenses are payable on the same basis as any other X-ray expense. |
| **Chlamydia Screening Test Expenses**                   | Covered Medical Expense for Chlamydia Screening completed during the annual Woman’s Health exam or if medically necessary is payable as any other Laboratory Expense.                                                                                                                                     |
**Additional Benefits (continued)**

**Supplemental Medical Coverage**

The Policy Year maximum benefit per Accident or Sickness under the Student Health Insurance Plan described above is $50,000. If you have purchased the Basic Student Health Insurance Plan at Bentley, you are eligible to purchase a Supplemental Plan to extend the Policy Year maximum benefit per Accident or Sickness to $250,000 for students and to $100,000 for dependents. Please contact Chickering Claims Administrators, Inc. for rates and an Enrollment Form at (800) 481-8814.

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## Additional Services and Discounts

As a participant in the Student Health Insurance Plan, you can also take advantage of the following services, discounts and programs. These services, discounts, and programs are not underwritten by Aetna.

<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision One® Program</td>
<td>This program allows you to purchase certain vision services and supplies at discounted rates. You can obtain more detailed information regarding services, supplies, and discounts, as well as a list of providers who provide the services, supplies, and discounts by contacting Chickering Claims Administrators, Inc. or by accessing Aetna’s DocFind at: <a href="http://www.chickering.com">www.chickering.com</a></td>
</tr>
<tr>
<td>Fitness Program</td>
<td>Aetna’s Fitness Program, offered in conjunction with GlobalFit™, offers discounted membership rates at over 1,500 independent fitness clubs nationwide, as well as discounts on certain home exercise equipment. There are no long-term contracts and GlobalFit offers convenient payment options. Contact Chickering Claims Administrators, Inc. for more information.</td>
</tr>
<tr>
<td>Aetna Natural Products and Services Program℠</td>
<td>Save money on many alternative therapies and products through our Aetna Natural Products and Services Program℠. Take advantage of discounted rates on chiropractic manipulation, acupuncture and massage therapy, and nutritional counseling. Through participating retailers, you can also save on vitamins, supplements, and natural products such as aromatherapy, yoga tools, and homeopathy.</td>
</tr>
<tr>
<td>Vital Savings by Aetna℠</td>
<td>Vital Savings by Aetna℠ – offers you a great way to get significant discounts on a wide array of services. The Vital Savings card gives you access to savings on dental and vision care. The cost is $25 for students for annual membership September 1, 2007, through August 31, 2008. For complete details and to enroll, visit <a href="http://www.chickering.com">www.chickering.com</a>. Click on “Find Your School” and enter 890428 as your Policy Number.</td>
</tr>
</tbody>
</table>
With our Aetna Dental PPO plan, you can choose to visit a participating or non-participating dentist for care. Enrollment in the Aetna Dental PPO plan is available even without enrollment into the student health insurance plan offered through Bentley. The cost is $405 for students for annual membership August 15, 2007, through August 14, 2008. Enroll and search dentists online at www.chickering.com; click on “Find Your School” and enter your school name or Policy Number 890428.

General Provisions

State Mandated Benefits
The Plan will always pay benefits in accordance with any applicable Commonwealth of Massachusetts Insurance Law(s).

Subrogation/Reimbursement Right of Recovery Provision
Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person’s Injuries or illnesses, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including the full amount the Covered Person receives, from all potentially responsible parties. A “Covered Person” includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or Dependent of any Covered Person, entitled to receive any benefits from this Plan.

As used in this provision, the term “responsible party” means any party possibly responsible for making any payment to a Covered Person or on a Covered Person’s behalf due to a Covered Person’s Injuries or illnesses or any insurance coverage responsible for making such payment, including but not limited to:
• Uninsured motorist coverage;
• Underinsured motorist coverage;
• Personal umbrella coverage;
• Med-pay coverage;
• Workers compensation coverage;
• No-fault automobile insurance coverage; or
• Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna’s subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna’s efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to Injuries sustained by the Covered Person.
The Covered Person acknowledges that this Plan’s subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person’s damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person’s damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as “pain and suffering” or “non-economic damages” only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Covered Person and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

**Definitions**

*Accident:* An occurrence which (a) is unforeseen, (b) is not due to or contributed to by Sickness or disease of any kind, and (c) causes Injury.

*Actual Charge:* The Actual Charge made for a covered service by the provider that furnishes it.

*Aggregate Maximum:* The maximum benefit that will be paid under the Policy for each sickness or Injury incurred by a Covered Person during the Policy Year.

*Brand-Name Prescription Drug or Medicine:* A Prescription Drug, which is protected by trademark registration.

*Copay:* This is a fee charged to a Covered Person for Covered Medical Expenses. Copay amounts are the responsibility of the Covered Person.

*Covered Medical Expenses:* Those charges for any treatment, service, or supplies covered by the Policy which are: (a) not in excess of the Reasonable Charges, or (b) not in excess of the charges that would have been made in the absence of this coverage, and (c) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits provision.

*Covered Person:* A covered student or dependent whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.
**Deductible:** A specific amount of Covered Medical Expenses that must be incurred and paid for by the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.

**Elective Treatment:** Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered 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 acute purulent sinusitis; treatment for weight reduction; learning disabilities; temporomandibular joint (TMJ) dysfunction; immunization; vaccines; and routine physical examinations.

**Emergency Medical Condition:** This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:
- Placing the person’s health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.
It does include a Accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, or care for non-emergency illness.

**Generic Prescription Drug or Medicine:** A Prescription Drug that is not protected by trademark registration but is produced and sold under the chemical formulation name.

**Injury:** Bodily Injury caused by an Accident; this includes related conditions and recurrent symptoms of such Injury.

**Medically Necessary:** A service or supply that is necessary, and appropriate, for the diagnosis or treatment of a Sickness, or Injury, based on generally accepted current medical practice. In order for a treatment, service, or supply to be considered Medically Necessary, the service or supply must:
- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the Sickness or Injury involved and the person’s overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person’s overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the Sickness or Injury involved and the person’s overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person’s overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.
In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information relating to the affected person’s health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna’s attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional; or
- Those furnished mainly for the personal comfort, or convenience, of the person, any person who cares for him or her, or any person who is part of his or her family, any health care provider, or health care facility; or
- Those furnished solely because the person is an inpatient on any day on which the person’s Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a Physician’s or a dentist’s office, or other less costly setting.

**Negotiated Charge:** The maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under the Plan.

**Non-Preferred Care:** A health care service or supply furnished by a health care provider that is not a Preferred Care Provider, if, as determined by Aetna (a) the service or supply could have been provided by a Preferred Care Provider and (b) the provider is of a type that falls into one or more of the categories of providers listed in the Directory.

**Non-Preferred Care Provider (or Non-Preferred Provider):** A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

**Non-Preferred Pharmacy:** A Pharmacy not party to a contract with Aetna, or a Pharmacy that is party to such a contract, but which does not dispense Prescription Drugs in accordance with its terms.

**Pharmacy:** An establishment where Prescription Drugs are legally dispensed.

**Physician:** (a) A legally qualified Physician licensed by the state in which he or she practices; and (b) any licensed nurse, midwife, registered nurse anesthetist, or other licensed medical practitioner whose services are required to be covered, by law, and who renders such services within the scope of his or her license. For the treatment of mental illness, the term “Physician” also includes a licensed clinical psychologist, licensed clinical social worker, and a licensed clinical psychiatric nurse practitioner who is acting within the scope of his or her license; and any other practitioner whose services are required to be covered, by law, when rendered by that practitioner.
**Preferred Care Provider (or Preferred Provider):** A health care provider that has contracted to furnish services or supplies for a Negotiated Charge, but only if the provider is, with Aetna’s consent, included in the Directory as a Preferred Care Provider for the service or supply involved, and the class of which the Covered Person is a member.

**Preferred Health Care:** A health care service or supply that is furnished by a Hospital or Physician that is a Preferred Care Provider. It also includes a health care service or supply furnished by a Hospital or Physician that is not a Preferred Care Provider:
- For an Emergency Medical Condition when travel to a Preferred Care Provider is not feasible.
- For treatment or services furnished by a Physician that has a type of practice that is not listed in the Directory but whose services are required to be covered by law.
- For treatment or services furnished by a Physician within the geographic area covered in the Directory, but only if a Preferred Care Provider is not reasonably available, provided you contact Aetna and Aetna confirms that a Preferred Care Provider is not reasonably available.

**Preferred Pharmacy:** A Pharmacy which is party to a contract with Aetna to dispense drugs to persons covered under the Policy, but only while the contract remains in effect; and when the Pharmacy dispenses a Prescription Drug under the terms of its contract with Aetna.

**Prescription:** An order of a prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

**Reasonable Charge:** Only that part of a charge which is reasonable is covered. The Reasonable Charge for a service or supply is the lowest of:
- The provider’s usual charge for furnishing it; and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, Aetna may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.

In determining the Reasonable Charge for a service or supply that is:
- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:
- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.
Service Area: The geographic area, as determined by Aetna, in which Preferred Care Providers are located.

Sickness: A disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy.

Exclusions

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for: (a) Injury to sound, natural teeth; or (b) extraction of impacted wisdom teeth as provided elsewhere in the Policy.

2. Expenses incurred for services normally provided without charge by the Policyholder’s health service, infirmary, hospital, or by health care providers employed by the Policyholder.

3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or Prescriptions or examinations except as required for repair caused by a covered Injury.

4. Expenses incurred as a result of Injury due to participation in a riot. “Participation in a riot” means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.

5. Expenses incurred as a result of an 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 regular, published schedules on a regularly established route.

6. Expenses incurred as a result of an Injury or Sickness for which benefits are payable under any Workers’ Compensation or Occupational Disease Law.

7. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person entering the armed forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.

8. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. Expenses incurred for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies, which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:
   (a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect (including hare lip and webbed fingers or toes), or as a direct result of disease, or from surgery performed to treat a Sickness or Injury.
   (b) Repair an Injury (including reconstructive surgery for a prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident, which causes the Injury, or in the next Policy Year.

10. Expenses for Injuries sustained as a result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

11. Expenses incurred for allergy shots and injections, preventive medicines, serums, vaccines, or oral contraceptives unless otherwise provided in the Policy.

12. Expense incurred for a treatment, service, or supply, which is not Medically Necessary, as determined by Aetna, for the diagnosis care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended, or approved, by the person’s attending Physician or dentist.

   In order for a treatment, service, or supply, to be considered Medically Necessary, the service or supply must:
   • Be care, or treatment, which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Sickness or Injury involved, and the person’s overall health condition;
   • Be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Sickness or Injury involved, and the person’s overall health condition; and
   • As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests.

   In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: information relating to the affected person’s health status, reports in peer reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment, the opinion of health professionals in the generally recognized health specialty involved, and any other relevant information brought to Aetna’s attention.
In no event will the following services or supplies be considered to be Medically Necessary:
• Those that do not require the technical skills of a medical, mental health, or dental professional; or
• Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any person who is part of his or her family, any health care provider, or health care facility; or
• Those furnished solely because the person is an inpatient on any day on which the person’s Sickness or Injury could safely, and adequately, be diagnosed, or treated, while not confined; or
• Those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a Physician’s or a dentist’s office, or other less costly setting.

13. Expenses incurred for any services rendered by a family member of a Covered Person’s immediate family or a person who lives in the Covered Person’s home.

14. Expenses incurred for the treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain unless otherwise provided in the Policy.

15. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.

16. Expenses incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to: by whom they are prescribed; or by whom they are recommended; or by whom or by which they are performed.

17. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.

18. Expenses covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance, whether or not a claim is made for such benefits.

19. Expenses for treatment of Injury to the extent benefits are payable under any state no-fault automobile coverage, or any first-party medical benefits payable under any other mandatory no-fault law.

20. Expense for elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy (see summary of benefits).

21. Expenses incurred as a result of commission of a felony.
22. Expenses incurred for or in connection with procedures, services, or supplies that are, as
determined by Aetna, to be experimental or investigational. A drug, device, procedure, or
treatment will be determined to be experimental or investigational if:
• There are insufficient outcomes data available from controlled clinical trials published in
the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or
Injury involved; or
• If required by the FDA, approval has not been granted for marketing; or
• A recognized national medical or dental society or regulatory agency has determined, in
writing, that it is experimental, investigational, or for research purposes; or
• The written protocol or protocols used by the treating facility, or the protocol or protocols
of any other facility studying substantially the same drug, device, procedure, or treatment,
or the written informed consent used by the treating facility, or by another facility studying
the same drug, device, procedure, or treatment, states that it is experimental,
investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs)
received in connection with a disease, if Aetna determines that:
• The disease can be expected to cause death within one year, in the absence of effective
treatment; and
• The care or treatment is effective for that disease, or shows promise of being effective for that
disease, as demonstrated by scientific data. In making this determination, Aetna will take into
account the results of a review by a panel of independent medical professionals. They will be
selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:
• Have been granted treatment investigational new drug (IND), or Group c/treatment IND
status; or
• Are being studied at the Phase III level in a national clinical trial, sponsored by the
National Cancer Institute; If Aetna determines that available, scientific evidence
demonstrates that the drug is effective, or shows promise of being effective, for the disease.

23. Expenses for treatment of Injury or Sickness to the extent payment is made, as a judgment or
settlement, by any person deemed responsible for the Injury or Sickness (or their insurers).

24. Expenses incurred for or related to sex change surgery or to any treatment of gender identity
disorders.

25. Expenses incurred for routine physical exams, routine vision exams, routine dental exams,
routine hearing exams, immunizations, or other preventive services and supplies, except to
the extent coverage for such exams, immunizations, services, or supplies is specifically
provided in the Policy.

26. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.

27. Expenses incurred for breast reduction/mammoplasty.

28. Expenses incurred for gynecomastia (male breasts).
29. Expenses incurred for sinus surgery, except for acute purulent sinusitis.

30. Expenses for charges that are not Reasonable Charges, as determined by Aetna.

31. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as part of their training in that field.

32. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when Medically Necessary; because the Covered Person is diabetic; or suffers from circulatory problems.

33. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.

Any exclusion listed will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

Extension of Benefits

If a Covered Person is confined to a hospital on the date his/her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement shall be payable in accordance with the Policy, but only while they are incurred during the 90-day period following such termination of insurance.

Termination of Insurance

Benefits are payable under the Policy only for those Covered Medical Expenses incurred while the Policy is in effect as to the Covered Person. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

Mandated Continuation Language (required)

Insurance may be continued for incapacitated dependent children who reach the age at which insurance would otherwise cease. The dependent child must be chiefly dependent for support upon the covered student and be incapable of self-sustaining employment because of mental or physical handicap.
Claim Procedure

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by Chickering Claims Administrators, Inc.

P.O. Box 15708
Boston, MA 02215-0014
(800) 481-8814
(617) 218-8400 (outside United States)
Customer Service Representatives are available Monday through Friday, 8:30 a.m. to 5:30 p.m. (ET).

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. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Chickering Claims Administrators, Inc., within 60 days from the date appearing on the Explanation of Benefits (EOB).
4. If service is provided in a foreign country, bills must be itemized and translated into English in order to be reviewed.

How To Appeal a Claim

In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person’s request must be made in writing within 60 days of receipt of the Explanation of Benefits (EOB). The Covered Person’s request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician’s office notes, operative reports, Physician’s letter of Medical Necessity, etc.).

Prescription Drug Claim Procedure

Preferred Care: When obtaining a covered Prescription, please present your Chickering ID card to an Aetna Preferred Pharmacy along with your applicable Copay. The Pharmacy will bill Aetna for the cost of the drug, plus a dispensing fee, less the Copay amount. Preferred Care Pharmacy locations can be obtained by accessing Aetna’s Docfind at: www.chickering.com.

When you need to fill a Prescription and do not have your ID card with you, you may obtain your Prescription from an Aetna Preferred Pharmacy and be reimbursed for covered medications by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications directly by Aetna.

Non-Preferred Care: You may obtain your Prescription from a Non-Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications at the Reasonable Charge, less any applicable Deductible, directly by Aetna.
Please note: You will be required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy.

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at (888) 792-8742. When submitting a claim, please include all Prescription receipts, indicate that you attend Bentley and include your name, address, and student identification number.

**Accidental Death and Dismemberment Benefits**

This insurance coverage provides Accidental Death and Dismemberment coverage underwritten by Unum Provident Life Insurance Company of America. Benefits are payable for the Accidental Death and Dismemberment of the eligible insureds of up to a maximum of $10,000. (Exclusions and limitations may apply. For definitions of eligibility and a complete loss schedule, detailing the benefits received for accidental death, dismemberment, loss of sight, speech or hearing, please refer to your Master Policy available at your school.)

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at (800) 481-8814 for the appropriate claim forms.

**Worldwide Emergency Travel Assistance Services**

These services are designed to protect Bentley students and/or eligible dependents when traveling more than 100 miles from home anywhere in the world. Medical Repatriation and Return of Mortal Remains services are also available at the Covered Person’s campus location.

If you experience a medical emergency while traveling more than 100 miles from home or campus, you have access to a comprehensive group of emergency assistance services provided by Assist America, Inc.

Eligible Covered Persons have immediate access to doctors, hospitals, Pharmacies, and other services when faced with an emergency while traveling. The Assist America Operations Center can be reached 24 hours a day, 365 days a year, to provide services including: medical consultation and evaluation; medical referrals; foreign hospital admission guarantee; prescription assistance; lost luggage assistance; legal and interpreter assistance; and travel information such as Visa and passport requirements, travel advisories, etc.
### Medical Evacuation and Return of Mortal Remains Services

In the event that a Covered Person becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate you to the nearest facility capable of providing required care. In the event of death of a Covered Person, Assist America will render every possible assistance in return of mortal remains including locating a sending funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container, as well as paying for transport.

**Please note:** Any third party expenses incurred are the responsibility of the Covered Person. An Assist America ID card will be supplied to you once you enroll in The Chickering Student Health Insurance Plan. Please remember to carry your Assist America card and call toll-free within the U.S. at *(800) 872-1414* or outside the U.S. call collect (dial U.S. access code) **plus 301-656-4152**, in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of over 600,000 pre-qualified medical providers. Assist America Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider.

**NOTE:** Assist America pays for all Assistance Services it provides. All Assistance Services must be arranged and provided by Assist America. Assist America does not reimburse for services not provided by Assist America.

The Assist America program meets and exceeds the requirements of USIA for International Students & Scholars.

Emergency Travel Assistance Services are administered by Assist America, Inc.

### Traveler’s Assistance Services

Worldwide Assistance Services offers a range of services for Covered Persons faced with emergencies while traveling. Services include, but are not limited to, 24-hour telephone access for medical emergencies; medical consultation and assistance in locating appropriate medical care; legal and interpreter referrals; assistance in overcoming language barriers; emergency message services; and emergency Prescription services. Any third-party expenses incurred are the responsibility of the Covered Person. All services must be coordinated through and provided by Worldwide Assistance Services, Inc.

Students may contact Worldwide Assistance Services, Inc. at the numbers above, for assistance prior to traveling, 24 hours a day, 365 days a year. An ID card with the access help line number will be provided to you once you enroll in the Chickering Student Health Insurance Plan.
Important Note

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. A copy is on file with the Chickering Group and with Student Health Services at Bentley. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

If you wish to receive a copy of the Master Policy applicable for your Plan, please contact Chickering Claims Administrators, Inc. at (800) 481-8814.

This student plan fulfills the definition of creditable coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the customer service number on your ID card.

Offered by:
Chickering Benefit Planning Insurance Agency, Inc.
1 Charles Park
Cambridge, MA 02142

Administered by:
Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 481-8814

Underwritten by:
Aetna Life Insurance Company (ALIC)
Policy No. 890428

The Chickering Group is an internal business unit of Aetna Life Insurance Company
Aetna considers nonpublic personal member information (“NPI”) confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, or other related activities, we use NPI internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep NPI confidential as provided by applicable law. Participating network/preferred providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our notice describing in greater detail our practices concerning use and disclosure of NPI, please call the toll-free Customer Services number on your ID card or visit Chickering’s Student Connection Link on the internet at www.chickering.com.
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www.chickering.com
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