2008-2009

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

Bates College

Lewiston, Maine

Harvard Pilgrim HealthCare

Coverage underwritten by HPHC Insurance Company, Inc, an affiliate of Harvard Pilgrim Health Care, Inc., and administered by UnitedHealthcare **Student**Resources.

HPHC 06 BR-ME 18-1295-1

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy by calling us toll-free at 1-800-977-4698 or visiting us at www.uhcsr.com.

Eligibility

All students enrolled in 3 or more classes are automatically enrolled in this insurance Plan at registration. When the student's current insurance is not a domestic or U.S. based company, the student will be required to remain enrolled in this insurance plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

The Bates College Student Health Insurance Plan

This brochure is a brief description of the Student Health Insurance Plan made available to students through Bates College. This plan has been developed especially for Bates College Students. **The plan provides benefits for covered accident and sickness that occur on and off campus, on a world-wide basis, 24 hours per day, during the period for which premium has been paid.**

Bates College requires that all full time students enrolled in 3 or more classes carry health insurance. Students must verify that they have other adequate insurance coverage of at least $100,000 in order to waive automatic enrollement in the Bates College Student Health Insurance Plan. If you currently have coverage, it is your responsibility to determine that it meets or exceeds the coverage available through Bates College's Student Health Insurance Plan at home, has limited or no benefits while at College. Often a student covered by a parent's plan at home, has limited or no benefits while at college, other parts of the U.S. or in a foreign country. When reviewing your current medical insurance coverage, be sure it provides coverage to students who are over the age of 19, that it provides access to care in the State of Maine, and provides comprehensive coverage, extending beyond emergency care to include physician and hospital services. Students wishing to supplement their existing coverage by remaining in the Bates Plan may do so.

All students will automatically be enrolled in either the Bates College Student Health Insurance Plan or the International Insurance Plan.

Students who wish to have the expense for this coverage removed from the College charges may do so by providing other insurance information online through the "Garnet Gateway". See the section titled "Online Student Waiver Process" for directions on waiving the insurance plan. The deadline to waive coverage is **September 30, 2008**. For those students beginning in the Winter Term, the deadline to waive coverage is **January 31, 2009**. Students who complete the waiver by September 30, 2008 do not need to complete the waiver again for January. **No waivers will be accepted**.

ONLINE STUDENT WAIVER PROCESS

Fall Deadline is September 30, 2008

Winter Deadline is January 31, 2009

Bates College students may waive coverage if documented proof of comparable coverage in another health insurance plan is provided via the Online Waiver Form by the deadline. **No waivers will be accepted after the deadline**. Recognizing that health insurance situations may change, each year students will be asked to provide proof of comparable coverage in order to waive participation in the Bates College Student Health Insurance Plan. To document proof of comparable coverage, students must complete the Online Waiver Form. **The Online Student Waiver Process is the only accepted process for waiving the insurance**.

Before you access the Waiver Form, have your current health insurance ID card ready. You will need this information to complete the Online Waiver Form. In order to waive the insurance, you will need to know the name of your current insurance company, the policy number, and the policy holder name.

To complete the online process, log on to the Garnet Gateway and select the "Student Menu," then "Financial Records" and then choose the second option under Financial Records, "Student Health Insurance Waiver." Immediately upon submitting the Online Waiver Form, students will receive a confirmation number as documentation that the form has been submitted. Please print this confirmation for future reference; it is your documentation that the Online Waiver Form was submitted. **The deadline for completing the Online Waiver Process is September 30, 2008. For students beginning in the Winter Term, the deadline to waive coverage is January 31, 2009**. Students who complete the waiver by September 30, 2008 do not need to complete the waiver again for January.

Effective and Termination Dates

The Master Policy on file at the school becomes effective August 15, 2008. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates August 14, 2009. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

Refunds of premiums are allowed only upon entry into the armed forces.

Premium Rates

Annual	Winter
08/15/2008 - 8/14/2009	1/1/2009 - 8/14/2009
$656	$414

Extension of Benefits After Termination

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Totally Disabled 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 6 months after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

Pre-Admission Notification

Avidyn should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide the notification of any admission due to Medical Emergency.

Avidyn is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre- notification is not a guarantee that benefits will be paid.

Schedule of Medical Expense Benefits

Up To $100,000 Maximum Benefit Paid as Specified Below (For Each Injury or Sickness)

$100 Deductible (Per Insured Person) (Per Policy Year)

Coinsurance 80% except as noted below

The policy provides benefits for 80% of the Usual & Customary Charges incurred by an Insured Person for loss due to a Covered Injury or Sickness up to the $100,000 maximum for each Injury or Sickness. After an Out-of-Pocket Maximum of $5,000 has been satisfied, the Company will pay 100% of the Usual & Customary Charges up to the Policy Maximum of $100,000 per Injury or Sickness for the following Covered Medical Expenses: Physician Office Visits, Hospital & Non-Hospital X-Ray and Laboratory Expense, Medical Emergency, Room & Board, Surgery, Psychotherapy, Alcohol/Chemical Dependency and Durable Medical Equipment. The Out-of-Pocket Maximum is satisfied by compilation of the $100 Deductible and 20% coinsurance amounts from the above categories only. Co-payments and amounts in excess of the specific benefit maximums, non-covered services, and penalties do not apply towards the satisfying the Out-of-Pocket Maximum.

Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:

U&C = Usual & Customary Charges

max = maximum

INPATIENT

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

INPATIENT	
Routine Newborn Care, 4 days Hospital Confinement expense maximum, while Hospital Confined; and routine nursery care provided immediately after birth.	Paid as any other Sickness
Physiotherapy	80% of U&C
Surgeon's Fees, in accordance with data provided by Ingenix. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable. The maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of U&C
Assistant Surgeon	80% of U&C
Anesthetist, professional services administered in connection with inpatient surgery.	80% of U&C
Registered Nurse's Services	No Benefits
Physician's Visits, benefits are limited to one visit per day and do not apply when related to surgery.	80% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of U&C
Psychotherapy, benefits are limited to one visit per day.	See Benefits for Mental Illness
OUTPATIENT	
Surgeon's Fees, in accordance with data provided by Ingenix. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable. The maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of U&C

OUTPATIENT	
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of U&C
Assistant Surgeon	80% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of U&C
Physician's Visits, benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of U&C/ $10 copay per visit
Physiotherapy, benefits are limited to one visit per day.	Paid Under Physician's Visits
Medical Emergency Expenses, use of the emergency room and supplies. *(Copay waived if admitted.) (Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.)*	80% of U&C/ $50 copay per visit
Diagnostic X-ray & Laboratory Services	100% of U&C for the first $500/ 80% of U&C thereafter
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, physiotherapy, X-Rays and Lab Procedures.	80% of U&C
Radiation Therapy & Chemotherapy	80% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement. *(Includes Gardasil.)*	80% of U&C/ $300 maximum (Per Policy Year)
Prescription Drugs, *$1,000 maximum (Per Policy Year)* Prescriptions are only covered if filled at a UnitedHealthcare Network Pharmacy	$10 copay per prescription for Tier 1 / $25 copay per prescription for Tier 2 / up to a 31-day supply per prescription

OTHER	
Ambulance Services, *(Air transportation: 80% of Actual Charges up to $2,000 per trip by air.)*	80% of actual charges/ $500 per trip by ground transportation
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	80% of U&C
Consultant Physician Fees	No Benefits
Dental Treatment, made necessary by Injury to Sound, Natural Teeth.	100% of actual charges/ $250 per tooth
Maternity & Complications of Pregnancy	Paid as any other Sickness
Alcoholism/Chemical Dependency	See Benefits for Mental Illness
Elective Abortion	100% of actual charges/ $500 maximum (Per Policy Year)
Annual Physicals	100% of actual charges/ $200 maximum (Per Policy Year)
Learning Disability, *(Diagnostic Testing & Treatment for Learning Disabilities)*	80% of U&C/ $500 maximum (Per Policy Year)

UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits (up to 31 days) and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are a few Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

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

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

$25 Copay per prescription order or refill for a Tier 2 Prescription Drug up to 31 day supply

Your maximum allowed benefits is $1,000 Per Policy Year.

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

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

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply:

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

under this provision.

5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury; except as required by state mandate.

Definitions

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

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service 1-877-417-7345.

Maternity Testing

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered, if all other policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/AFP Screening; and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Pre-natal vitamins are not covered.

Excess Provision

Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance.

Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, this Excess Provision will not be applied to the first $100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

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

Mandated Benefits

Benefits for Annual Gynecological Examination and Pap Test

Benefits will be paid the same as any other Sickness for an annual gynecological examination including routine pelvic and clinical breast examinations. Benefits will also be paid the same as any other Sickness for screening Pap tests recommended by a Physician.

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

Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery

Benefits will be paid the same as any other Sickness for breast cancer treatment and post-mastectomy reconstruction.

Coverage for the treatment of breast cancer shall be provided for a period of time determined by the attending Physician, in consultation with the patient, to be Medically Necessary following a mastectomy, a lumpectomy or a lymph node dissection.

Post mastectomy reconstruction includes the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the Insured elects reconstruction and in the manner chosen by the Insured and the Physician.

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

Benefits for Mammogram

Benefits will be paid the same as any other Sickness for screening mammograms performed by Physicians that meet the standards established by the Department of Human Services rules relating to radiation protection. A screening mammogram also includes an additional radiological procedure recommended by a Physician when the results of an initial radiologic procedure are not definitive. Benefits will be provided for screening mammograms performed at least once a year for Insureds 40 years of age and over.

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

Benefits for Modified low-Protein Food Product

Benefits will be paid the same as any other Sickness for metabolic formula and Special Modified Low-Protein Food Products that have been prescribed by a licensed Physician for a person with an Inborn Error of Metabolism. Benefits shall be provided for metabolic formula and not to exceed $3,000 per policy year for Special Modified Low-Protein Food Products.

Inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. Special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

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

Benefits for Prostate Cancer Screening

Benefits will be paid the same as any other Sickness for Services For The Early Detection of Prostate Cancer. Services for the early detection of prostate cancer means the following procedures provided to a man for the purpose of early detection of prostate cancer: (a) a digital rectal examination; and (b) a prostate-specific antigen test. Benefits shall be provided for services for the early detection of prostate cancer, if recommended by a Physician, at least once a year for Insureds 50 years of age or older until an Insured reaches the age of 72.

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

Benefits for Chiropractic Services

Benefits will be paid the same as any other Sickness for services performed by a chiropractor to the extent that services are within the lawful scope of practice of a chiropractor licensed to practice in Maine. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

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

Benefits for Diabetes Treatment

Benefits will be paid the same as any other Sickness for the Medically Necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if: (1) the Insured's treating Physician or a Physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and (2) the diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

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

Benefits for Contraceptives

Benefits will be paid the same as any other Prescription Drugs or outpatient medical services for all prescription contraceptives approved by the federal Food and Drug Administration or for Outpatient Contraceptive Services.

"Outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive

methods to prevent an unintended pregnancy. The benefit may not be construed to apply to Prescription Drugs or devices that are designed to terminate a pregnancy

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

Benefits for Mental Illness

Benefits will be paid the same as any other Sickness for Mental Illness, Alcoholism and Drug Dependency.

Benefits for an Insured suffering from Mental Illness include the following: Inpatient care; Day treatment services; Outpatient services; Home health care services.

Mental illness shall include the following categories as defined in the Diagnostic and Statistical Manual, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia
(2) Dissociative disorders;
(3) Mood disorders;
(4) Anxiety disorders;
(5) Personality disorders;
(6) Paraphilias
(7) Attention deficit and disruptive behavior disorders;
(8) Pervasive development disorders;
(9) Tic disorders;
(10) Eating disorders, including bulimia and anorexia; and
(11) Substance abuse-related disorders.

Amounts payable for specific inpatient services are limited by the Schedule of Benefits. All outpatient expenses incurred for other or ancillary services stated on the Schedule of Benefits; and incurred as a result of Mental and Nervous Disorder and Alcoholism and Drug Dependency are subject to the above aggregate maximums.

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

Benefits for Clinical Trials

Benefits will be paid the same as any other Sickness for Routine Patient Costs in connection with participation in an Approved Clinical Trial.

Qualified Insured: An Insured is eligible for coverage for participation in an Approved Clinical Trial if the Insured meets the following conditions:

A. The Insured has a life-threatening Sickness for which no standard treatment is effective;
B. The Insured is eligible to participate according to the clinical trial protocol with respect to treatment of such Sickness;
C. The Insured's participation in the trial offers meaningful potential for significant clinical benefit to the Insured; and
D. The Insured's referring Physician has concluded that the Insured's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.

"Approved clinical trial," means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

"Routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

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

Benefits for Hospice Care Services

Benefits will be paid the same as any Sickness for Hospice Care Services to an Insured who is Terminally Ill.

Hospice Care Services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of Hospice Care Services. Coverage for Hospice Care Services will be provided whether the services are provided in a home setting or an inpatient setting.

"Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to an Insured who is terminally ill and that Insured's family. Hospice care services includes, but is not limited to, Physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services.

"Terminally ill" means an Insured that has a medical prognosis that the life expectancy is 12 months or less if the Sickness runs its normal course.

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

Benefits for General Anesthesia For Dentistry

Benefits will be paid the same as any Sickness for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the clinical status or underlying medical condition of an Insured requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital.

This section applies only to general anesthesia and associated facility charges for only the following Insureds:

A. Insureds, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

B. Insureds demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be

postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and

D. Insureds who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

This does not include benefits for any charges for the dental procedure itself, other than specifically provided for in the Schedule of Benefits, including, but not limited to, the professional fee of the dentist.

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

Benefits for Prosthetic Devices

Benefits will be paid the same as any Sickness for Prosthetic Devices determined by the Insured's Physician to be the most appropriate model that adequately meets the medical needs of the Insured. Benefits will include repair and replacement of a Prosthetic Device if the Insured's Physician determines such repair or replacement appropriate.

Prosthetic Device means an artificial device to replace, in whole or in part, an arm or a leg.

No coverage will be provided for a Prosthetic Device that contains a microprocessor or that is designed exclusively for athletic purposes.

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

Benefits for Off-Label Drug Use

If benefits are payable for Prescription Drugs under this policy benefits will be paid the same as any other Prescription Drug, including medically necessary services associated with the administration of such drugs, for the Off-Label Use of Prescription Drugs for the treatment of cancer or HIV/AIDS.

Benefits will not be denied for Prescription Drugs under this provision based on Medical Necessity, unless such denial is unrelated to the legal status of the drug's use. Benefits will not be paid for Prescription Drugs under this provision where the use is contraindicated by the federal Food and Drug Administration.

"Off-Label Use" means the use of a federal Food and Drug Administration approved drug for indications other than those stated in labeling that it has approved. The drug need not have been approved for the treatment of cancer or of HIV/AIDS if the use of such drug is supported by one or more citations in (a) the United States Pharmacopeia Drug Information or its successors; (b) the American Hospital Formulary Service Drug Information or its successors; or (c) Peer-reviewed Medical Literature.

"Peer-reviewed Medical Literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals. These articles must present evidence that supports the Off-Label Use as generally safe and effective.

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

Benefits for Hearing Aid

Benefits will be provided for the purchase of a Hearing Aid for each hearing-impaired ear for an Insured Person who is 5 years of age or under. The hearing loss must be documented by a Physician or audiologist. The Hearing Aid must be purchased from an audiologist or appropriately licensed hearing aid dealer. Benefits are limited to $1,400 per Hearing Aid for each hearing-impaired ear every 36 months.

"Hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

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

Definitions

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

PRE-EXISTING CONDITION means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

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

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges. The Insured may be billed for any charges which exceed the Usual and Customary Charges. The Insured may call the Company at 1-800-977-4698 for the maximum Usual and Customary Charge for a specified service.

Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Learning disabilities, except as specifically provided in the policy;
2. Congenital conditions;except as specifically provided for Newborn or Adopted Infants;
3. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy; or for newborn or adopted children;
4. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
5. Elective Surgery or Elective Treatment;
6. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
7. Hearing examinations or hearing aids; except as specifically provided under the Benefits for Hearing Aid; or other treatment for hearing defects and problems. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
8. Preventive medicines or vaccines, except where required for treatment of a covered Injury; except as specifically provided in the policy;
9. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
10. Injury sustained while (a) participating in any club, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
11. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
12. Pre-existing Conditions, except for individuals who have been continuously insured under the school’s student insurance policy for at least 6 months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy;
13. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; except as specifically provided in the Benefits for Diabetes Treatment;
    b) Biological sera, blood or blood products administered on an outpatient basis;

c) Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs or as specifically provided in the Benefits for Off-Label Drug Use;

d) Products used for cosmetic purposes;

e) Drugs used to treat or cure baldness; anabolic steroids used for body building;

f) Anorectics - drugs used for the purpose of weight control;

g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;

h) Growth hormones; or

i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

14. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
15. Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
16. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
17. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
18. Temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and /or other surgical correction thereof;
19. Skydiving, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
20. Supplies, except as specifically provided in the policy;
21. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and
22. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

Collegiate Assistance Program

Insured Students have access to nurse advice and health information 24 hours a day, 7 days a week by dialing 877-643-5130. The Collegiate Assistance Program is staffed by Registered Nurses who can help students determine if they need to seek medical care, understand their medications or medical procedures, or learn ways to stay healthy.

Scholastic Emergency Services
Global Emergency Medical Assistance

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

International Students: You are eligible to receive SES services worldwide, except in your home country.

Domestic Students: You are eligible for SES services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

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

Key Services include:

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

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

To access services please call:

(877) 488-9833 Toll-free within the United States

(609) 452-8570 Collect outside the United States

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

* When calling SES's Operations Center, please be prepared to provide:

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

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure for Program Guidelines as well as limitations and exclusions pertaining to the SES program.

Complaint Resolution

Insured Persons, Preferred Providers, Out-of-Network Providers or their representatives with questions or complaints may call the Customer Service Department at 1-800-.977-4698 If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

Online Access to Account Information

UnitedHealthcare **Student**Resources insureds have online access to claims status, EOBs, correspondence and coverage information via My Account at www.uhcsr.com. Insureds can also print a temporary ID card, request a replacement ID card and locate network providers from My Account.

If you don't already have an online account, simply select the "Create an Account" link from the home page at www.uhcsr.com. Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from www.uhcsr.com to access your account information.

Temporary ID Card

Harvard Pilgrim HealthCare Student Insurance Plan

Name: _____

ID Number: _____ Policy #: 2008-1295-1

Group Name: Bates College

Customer Service call 1-800-767-0700
RX Vendor Group #: USTR6107 RX Bin #: 610014

Administered by UnitedHealthcare StudentResources
07-HP1 Coverage Underwritten by HPHC Insurance Company, Inc.

www.uhcsr.com

NOTICE TO MEMBERS
For emergencies, call 911. For emergencies while traveling in the US, call Scholastic Emergency Services 1-877-488-9833. Outside the US, call collect 1-609-452-8570. Reference # 01-AA-SID-01031.

NOTICE TO ALL HEALTHCARE PROVIDERS
This card is not a guarantee of coverage. For information concerning coverage, co-payment and claim instructions, please call Customer Service at the number listed on the front of this card.

CLAIMS INSTRUCTIONS
Please mail all medical and hospital bills along with the insured student's name and patient's name, ID number, address, and the name of the college or university under which the student is insured to: StudentResources, PO Box 809025, Dallas, TX 75380-9025.

For electronic submission: Emdeon (formerly WebMD) # 74227

Claim Procedure

In the event of Injury or Sickness, students should:

1. Report to the Health Center for treatment or in the case of an emergency, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, Social Security number and name of the College under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by:
HPHC Insurance Company
and
Administered by
UnitedHealthcare Student Resoruces

Submit all Claims or Inquiries to:

HPHC Insurance Company
c/o UnitedHealthcare **Student**Resources
P.O. Box 809024
Dallas, Texas 75380-9024
1-800-977-4698

customerservice@uhcsr.com

claims@uhcsr.com

Sales/Marketing Services:

UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
1-800-237-0903
E-Mail: info@uhcsr.com

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

This Brochure is based on Policy # 2008-1295-1 v6