

Student Injury & Sickness Insurance



College of the Holy Cross Worcester, MA 2009-2010

For claim information, call

Bollinger, Inc.

866-267-0092 (Claims/Coverage)

800-526-1379 (Other Questions)

(the "Plan Administrator")

Underwritten by:

Monumental Life Insurance Company

Cedar Rapids, Iowa

(the "Company")

Please visit us on the web

www.BollingerColleges.com/HolyCross

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College of Holy Cross

Student Medical Benefit Plan - Temporary I.D. Card

This is to certify that as of August 1, 2009 insurance coverage is provided in accordance with all terms and provisions of Policy No. CMA804F issued to the above named college for the student named below.

Name	Social Security No.	
Street Address		
Town	State	Zip Code

This coverage expires August 1, 2010

UNDERWRITTEN BY:

**Monumental Life
Insurance Company**

CEDAR RAPIDS, IOWA

PREFERRED PROVIDER NETWORK:



Preferred provider network, claim forms and plan benefits
available on website:

www.BollingerColleges.com/HolyCross

ADMINISTERED BY:

Bollinger
Insurance Solutions

101 JFK Parkway
P.O. Box 727
Short Hills, NJ 07078
866-267-0092

PREFERRED PROVIDER ORGANIZATION

The Plan Administrator contracts with a Preferred Provider Organization (“PPO”), First Health Network, for access to providers in the Commonwealth of Massachusetts and elsewhere in the United States.

The most favorable reimbursement rates for benefits outlined in the Policy are based upon medical treatment being received from one of the preferred providers. The PPO gives the Covered Person access to a network of Physicians, Hospitals and other health care providers, who have agreed to accept lower rates for their services.

For updated information on the preferred provider in your area visit the website at

www.BollingerColleges.com/HolyCross

Covered Health Services may be obtained from any health care practitioner, however the Covered Person should be aware that outside the coverage of this Plan, he/she can use the resources of the Student Health Center when first seeking non-emergency treatment at a reduced charge or no charge.

Participation of individual preferred providers is subject to change without prior notice. It is the responsibility of the Covered Person to verify preferred provider status at the time services are rendered. Deductibles, co-payments or coinsurance are the responsibility of the Covered Person.

If a Covered Person seeks treatment from a non-participating provider due to Medical Emergency or in the event the nearest PPO provider cannot be reached, the benefit payable under the Policy will not be reduced.

MAXIMUM BENEFITS

The maximum aggregate indemnity payable for all benefits for each covered Injury or each covered Sickness is \$75,000.00.

SCHEDULE OF BENEFITS

INJURY AND SICKNESS EXPENSE BENEFITS

BENEFITS PROVIDED BY PREFERRED PROVIDERS/IN-NETWORK PROVIDERS

Subject to the limitations stated below, all Covered Medical Expenses will be paid at 100% of the preferred allowance to a maximum of \$25,000, then 80% to the \$75,000 aggregate maximum. Benefits will also be paid as a Preferred/In-Network Provider if the following situations occur:

1. A Preferred Provider is not reasonably available in your area; or
2. The Covered Medical Expense is incurred due to a Medical Emergency.

BENEFITS PROVIDED BY OUT-OF-NETWORK PROVIDERS

After the Deductible has been satisfied, if any, benefits as listed below in the Schedule of Benefits will be paid at 80% of the Usual and Customary Charges incurred up to \$75,000. Benefit levels for health care services rendered by out-of-network providers shall be at least 80% of the benefit levels for services rendered by Preferred Providers.

INPATIENT HOSPITALIZATION BENEFITS

1. Hospital Room and Board Expenses - up to the semi-private room or intensive care unit rate.
2. Hospital Miscellaneous Confinement Expenses
3. Physician's Fees - covered expenses incurred for non-surgery related visits for each Injury or Sickness.

OUTPATIENT BENEFITS (EXCLUDING SURGERY)

1. Covered expenses incurred up to a maximum of \$1,500 for each Injury or Sickness for the following services and supplies; expenses incurred in a Physician's office, hospital outpatient department or emergency room, clinical lab, radiology facility licensed by the state. The following deductibles apply to each Injury or Sickness:
 - A \$25 deductible for any covered hospital emergency room or outpatient department visit that does not result in an admission;
 - B. \$10 deductible for each covered physician's office visit.

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2. High cost procedure - In addition to the above, for specific covered outpatient procedures costing over \$200, benefits will be paid up to a maximum benefit of \$2,000 for each Injury or Sickness.

SURGICAL BENEFITS

1. Covered expenses incurred up to a maximum of \$5,000 for surgery performed on either an inpatient or outpatient basis for each surgical procedure.
2. Anesthetist and assistant surgeons will be reimbursed for actual covered expenses up to an amount not to exceed 30% of the amount reimbursed under the surgeons benefit for each surgical procedure.

AMBULANCE BENEFITS

Up to a maximum of \$350 for the use of a covered community, hospital or private ambulance service in a emergency for each covered Injury or each covered Sickness.

DENTAL BENEFITS

The Company will pay the covered expenses incurred up to a maximum of \$1,000 per Injury for dental treatment as a result of accidental Injury to sound natural teeth. The Company will pay the covered expense incurred up to \$200 per tooth for the surgical removal of unerupted impacted or infected wisdom teeth.

PRESCRIPTION BENEFITS

Following a \$5.00 co-payment for each prescription, we will pay 100% of the covered expenses up to a maximum of \$500 per Policy term.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

In the event of the Accidental Death or Dismemberment of a Covered Person, benefits are payable up to a maximum of \$10,000.

INTERPRETER AND TRANSLATION SERVICES AVAILABLE

We provide, upon request, interpreter and translation services related to administrative procedures and claims processing. This service is available to a Covered Person by contacting the Plan Administrator, Bollinger, Inc. at 1-866-267-0092.

ELIGIBILITY

Massachusetts state law requires all full-time and qualifying part-time students to enroll in a Student Accident and Sickness plan unless satisfactory evidence is provided to the school that the student is enrolled in comparable coverage for the full academic year. A part-time student is one who is participating at least 75% of the academic requirements for full-time students. The deadline to waive coverage is August 1, 2009.

EFFECTIVE AND TERMINATION DATES

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2009. Coverage becomes effective on that date. The Master Policy terminates at 12:01 a.m. on August 1, 2010. Coverage terminates on that date or at the end of the period through which the rate is paid, whichever is earlier. A refund of the rate is allowed upon entry into the armed forces.

You must meet the eligibility requirements listed above each time you pay a premium to continue coverage.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this plan ceases on the termination date. However, if a Covered Person is Hospital Confined on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date, Covered Medical Expenses for such Injury or Sickness will continue to be paid until the completion of his Hospital Confinement but not to exceed 31 days from the expiration date of coverage.

After the "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

The total payments made in respect of the Covered Person for each condition both before and after the termination date will never exceed the Maximum Benefit.

COVERAGE RATES

The cost (for student only) for this insurance program is:

Annual Term:	\$815
Second Semester:	\$518

DEFINITIONS

CO-INSURANCE means the out-of-pocket expenses to be paid by the Covered Person as a percentage of the Covered Medical Expenses.

Covered Medical Expenses are usual, customary, and Medically Necessary charges that are:

- 1) not in excess of the maximum amount payable for services as specified in the policy schedule;
- 2) in excess of any deductible amount; and
- 3) incurred while the Covered Person's coverage under the Policy is in force.

ELECTIVE SURGERY means any surgery or treatment that is not Medically Necessary, including any service, treatment, or supply that is deemed by us to be research or experimental; or is not recognized as generally accepted medical practice in the United States. Elective Surgery and Elective Treatment do not include any procedures deemed a Medical Necessity. Elective Surgery does not mean a Cosmetic Procedure required to correct an Injury for which benefits are otherwise payable under the Policy.

Elective Surgery and Elective Treatment includes but is not limited to surgery and/or treatment for acne; acupuncture; allergy and allergy vials, including allergy testing; bio-feedback type services; birth control; breast implants, unless provided for under Mandated Benefits; breast reduction, unless provided for under Mandated Benefits; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the Policy, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are otherwise payable under the Policy; deviated nasal septum, including submucous resection and/or other surgical correction; family planning; hair growth or removal; learning disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia or any kind), except for the treatment of an underlying covered Sickness; premarital examinations; preventive medicines or vaccines, except where required for the treatment of a covered Injury or under the Mandated Benefits section; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing; smoking cessation;

temporomandibular joint dysfunction (TMJ); tubal ligation; vasectomy; and weight loss or reduction.

EMERGENCY MEDICAL CONDITION means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of a Covered Person or another person in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part or with respect to pregnant women, as further defined in §1867(e)(1) (B) of the Social Security Act, 42 U.S.C. §1395(e) (1)(B).

HOSPITAL means an institution which meets all of the following requirements:

- 1) It must be operated according to law;
- 2) It must give 24-hour medical care, diagnosis and treatment to sick or injured on an in-patient basis for which a charge is made;
- 3) It must provide diagnostic and surgical facilities supervised by Physicians;
- 4) Registered Nurses must be on 24-hour call or duty;
- 5) The care must be given either on the Hospital's premises or in facilities available to the Hospital on a prearranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or skilled nursing facility. It is not a facility for the aged. It is not a place which primarily treats alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes.

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under the Policy, subject to credit for prior coverage. A Covered Person must begin receiving services, supplies or treatment within 90 days from the time of accident in order for it to be considered a covered Injury. All Injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of the Injuries must be the direct cause of loss and must not be caused by or contributed to by Sickness.

COVERED PERSON means an eligible student as outlined in this brochure who has paid the required premium. The words he, his and him refer to the Covered Person, regardless of gender.

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

MAXIMUM BENEFIT means the maximum amount payable for expenses incurred by a Covered Person for any on Injury or Sickness.

OUTPATIENT EXPENSE means those expenses incurred for Medically Necessary services received while not confined as a bed patient in a Hospital.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. He must be practicing within the scope of his license for the service or treatment given. He may not be the insured or a member of the Covered Person's immediate family.

PREFERRED PROVIDER ORGANIZATION means a diversified group of medical providers who have entered into agreements with the Plan Administrator or the Company to provide medical benefits and services to the Covered Persons.

SICKNESS means an illness or disease which first causes loss while the coverage is in effect and which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. It also includes Pregnancy.

USUAL AND CUSTOMARY CHARGE means those charges for necessary treatment and services that are reasonable for the treatment of cases of comparable severity and nature. This will be derived from the mean charge based on the experience in a related area of the service delivered.

MEDICAL EVACUATION AND REPATRIATION BENEFITS

Medical Evacuation. Upon receipt of due proof that a Covered

Person incurred expenses for Physician ordered Emergency Medical Evacuation, including medically appropriate transportation and Medically Necessary Care en route to the nearest suitable Hospital or to the Covered Person's home country, when the Covered Person is critically ill or injured and has been Hospital confined for at least 5 days, and appropriate local care is not available, we will pay the allowable charges incurred not to exceed \$10,000, subject to prior approval of the Plan Administrator for this Plan and the attending Physician.

Payment of a benefit under the terms of this provision is in lieu of all benefits otherwise payable under the plan and any riders. Insurance for the Covered Person ends upon the evacuation.

Repatriation. Upon receipt of due proof of a Covered Person's death, we will pay the allowable charges for the preparation and transportation of the deceased's body for burial or cremation in his home country or country of regular domicile subject to the approval of the Plan Administrator of the Policy. If applicable, such action will be in accordance with any international standards. The benefit payable is not to exceed the maximum benefit shown on the schedule, and death must occur at least 100 miles away from the Covered Person's city of residence. Benefits provided by this provision are paid in addition to any other benefits payable under the Policy.

MANDATED HEALTH BENEFITS

ALCOHOLISM TREATMENT BENEFIT

- a) In the case of benefits based upon confinement as an inpatient in a Hospital or in any other public or private facility providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and which is licensed by the Department of Public Health for those services, or in a residential alcohol treatment program as referred to in section 24 of chapter 90 of the Massachusetts Insurance Laws, benefits will not exceed 30 days in any policy year. Benefits for Alcoholism Inpatient Treatment will be paid at the Mental Health Limits when rendered in conjunction with qualified Mental Health Treatment.
- b) In the case of outpatient benefits, benefits shall not exceed a maximum of \$500.00 over a 12-month period,

for services furnished by: 1) a Hospital; or 2) by any public or private facility or portion thereof providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Department of Public Health for those purposes.

Consultants or treatment sessions shall be rendered by a Physician or psychotherapist fully licensed under the provisions of chapter 112 of the Massachusetts

Insurance Laws who devotes a substantial portion of his time treating intoxicated persons or alcoholics. Benefits for Alcoholism Outpatient Treatment will be paid at the Mental Health Limits when rendered in conjunction with qualified Mental Health Treatment.

BONE MARROW TRANSPLANTS FOR TREATMENT OF BREAST CANCER BENEFIT Benefits will be provided on the same basis as for any other Sickness for a bone marrow transplant or transplants for a Covered Person who has been diagnosed with breast cancer that has progressed to metastatic disease. However, eligibility for coverage must meet the criteria established by the Department of Public Health and which are consistent with medical research protocols reviewed and approved by the National Cancer Institute.

CARDIAC REHABILITATION BENEFIT Benefits will be provided on the same basis as any other Sickness for the expense of cardiac rehabilitation for a Covered Person. Covered Medical Expenses for cardiac rehabilitation shall mean multi-disciplinary, Medically necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a Hospital or other setting and which shall meet standards promulgated by the commissioner of public health. Benefits shall include, but are not limited to, outpatient treatment, which is to be initiated within twenty-six (26) weeks after diagnosis of such disease.

CLINICAL TRIAL BENEFIT

Benefits will be provided on the same basis as for any other Sickness for Patient Care Service furnished in a Qualified Clinical Trial.

Patient Care Service means a health care item or service that is furnished to a Covered Person in a Qualified Clinical Trial which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent

with the study protocol for the clinical trial, and would be covered if the patient did not participate in the clinical trial.

Qualified Clinical Trial must meet the following conditions: (1) the clinical trial is to treat cancer; (2) the clinical trial has been peer reviewed and approved by one of the following: (a) United States National Institutes of Health; (b) a cooperative group or center of the National Institutes of Health; (c) a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; (d) the United States Food and Drug Administration pursuant to an investigational new drug exemption; (e) the United States Departments of Defense or Veterans Affairs; or (f) with respect to Phase II, III and IV clinical trials only, a qualified institutional review board; (3) the facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience; (4) with respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center; (5) the patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial; (6) the patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards; (7) the available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial; (8) the clinical trial does not unjustifiably duplicate existing studies; and (9) the clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient.

CYTOLOGIC SCREENING AND MAMMOGRAPHIC EXAMINATIONS BENEFIT Benefits will be provided on the same basis as any other Sickness for: 1) an annual cytologic screening for women eighteen (18) years of age or older and 2) a baseline mammogram for women between the ages of thirty-five (35) and forty (40) and for an annual mammogram for women forty (40) years of age and older.

DIABETES TREATMENT: Benefits will be provided when a Covered Person incurs expenses for Medically Necessary Diabetes Equipment, Diabetes Supplies, and Diabetes Self-Management Training, including nutrition therapy for treat-

ment of type 1 diabetes, type 2 diabetes and gestational diabetes, on the same level as all other Sickness services and supplies.

Diabetes Self-Management Training means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes self-management training shall include the content areas listed in the National Standards for Diabetes Association, including medical nutrition therapy, as ascribed to “medical nutrition care” in the Dietetic and Nutrition Services Practice Act. If authorized by a Physician, diabetes self-management training may be provided as part of an office visit, group setting or home visit.

Diabetes Equipment means the following equipment when Medically Necessary and prescribed by a Physician: blood glucose monitors, including voice-synthesizers and magnifying aids for monitors designed to be used by blind individuals; therapeutic molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating physician and prescribed by a podiatrist or other qualified physician and furnished by a podiatrist, orthotist, prosthetist or pedorthist, insulin pumps and lancets and lancing devices.

Diabetes Supplies means the following supplies and pharmaceuticals when Medically Necessary and prescribed by a Physician: blood glucose monitoring strips for home use, urine glucose strips, ketone strips, insulin, syringes and needles, prescribed oral diabetes medications that influence blood sugar levels, laboratory tests, including glycosylated

hemoglobin, or HbA_{1c}, tests, urinary protein/microalbumin and lipid profiles, insulin pump supplies, insulin pens, supplies and equipment approved by the Federal Drug Administration for the purposes for which they have been prescribed.

ENTERAL FORMULA BENEFIT Benefits will be provided for nonprescription enteral formulas for home use for a Covered Person when a Physician has issued a written order for such formula and when Medically Necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of

amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed \$5,000 annually for any Covered Person. Benefits are provided for formulas that are taken orally as well as those that are administered by tube.

Benefits shall be subject to a co-payment for a 30-day supply of enteral formula that is equal to the co-payment required for outpatient Physician Visits.

HOME HEALTH CARE SERVICES BENEFIT Benefits shall be provided on the same basis as any other Sickness for Home Health Care Services.

Home Health Care Services means health care services for a Covered Person by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a patient's residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in provided skilled nursing or rehabilitation services. Said services shall include, but are not limited to, nursing and physical therapy. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aid and the use of durable medical equipment and supplies shall be provided to the extent such additional services are determined to be a Medically Necessary component of said nursing and physical therapy. Benefits for home health care service shall apply only when such services are Medically Necessary and provided in conjunction with a Physician approved Home Health Care Services plan.

HORMONE REPLACEMENT THERAPY BENEFIT AND OUTPATIENT CONTRACEPTIVE SERVICES BENEFIT Benefits shall be provided for outpatient services and outpatient prescription drugs and devices for peri- and post-menopausal women and Outpatient Contraceptive Services on the same basis as for other outpatient services and outpatient prescription drugs and devices.

Outpatient contraceptive services include consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration.

HOSPICE CARE: Upon proof a Covered Person is diagnosed with a covered Injury or Sickness, and therapeutic intervention directed toward the cure of the Injury or Sickness is no longer appropriate, and the Covered Person's medical prognosis is

one in which there is a life expectancy of six months or less as direct result of such Injury or Sickness, we will pay the Usual and Customary charges not to exceed the Maximum Benefit on the Schedule for services and supplies for hospice care prescribed by a Physician and provided by a licensed hospice agency, organization or unit. This benefit does not cover non-terminally ill patients who may be confined in: a convalescent home, rest or nursing facility; a skilled nursing facility; a rehabilitation unit or a facility that provides treatment for person suffering from mental disease or disorders, or care for the aged, drug addicts or alcoholics. For this benefit to be payable, we must be furnished a written statement from the attending Physician that the Covered Person is terminally ill within the terms of this benefit and a written statement from the hospice certifying the days on which services were provided.

HUMAN LEUKOCYTE ANTIGEN OR HISTOCOMPATIBILITY LOCUS ANTIGEN TESTING: Upon receipt of due proof a Covered Person incurred expenses for human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish the Covered Person student's bone marrow transplant donor suitability, we will pay the Usual and Customary charges incurred subject to the Maximum Benefit for Sickness Benefits on the Schedule. Cost of testing for A, B, or DR antigens or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health will be covered.

INFERTILITY TREATMENT BENEFIT Benefits will be provided on the same basis as any other Sickness for the diagnosis and treatment of Infertility to persons residing within the Commonwealth of Massachusetts to the same extent that benefits are provided for other pregnancy-related procedures. Benefits will include, but are not limited to, the following Non-experimental Infertility Procedures: Artificial Insemination (IA); In-Vitro Fertilization and Embryo Placement (IVF-EP); Gamete Intra-Fallopian Transfer (GIFT); 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 (ICSI) for the treatment of male factor infertility; and Zygote Intrafallopian Transfer (ZIFT). Benefits are not provided for the following Experimental Infertility Procedures: Any Experimental Infertility Procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner; Surrogacy; Reversal of Voluntary Sterilization; and Cryopreservation of eggs.

Infertility means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year.

Non-experimental Infertility Procedures means a procedure which is: 1) recognized as such by the American Fertility Society (AFS) or the American College of Obstetrics and Gynecology (ACOG) or another infertility expert recognized as such by the Commissioner; and 2) incorporated as such in this provision by the Commissioner after a public hearing pursuant to M.G.L. c. 30A.

Experimental Infertility Procedures means a procedure not yet recognized as non-experimental.

Benefits under this provision shall be determined without regard to any Pre-existing Condition limitations.

INITIAL PROSTHETIC DEVICE AND RECONSTRUCTIVE SURGERY BENEFIT Benefits will be provided for the surgical procedure known as mastectomy and the initial prosthetic device or reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy. When a mastectomy is performed and there is no evidence of malignancy, benefits will be limited to the cost of the prosthesis or reconstructive surgery to within 2 years after the date of the mastectomy. Benefits for the prosthetic device and reconstructive surgery shall be subject to the Deductible and coinsurance provisions applied to the mastectomy and all other terms and conditions applicable to other benefits under the Policy.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

LEAD POISONING BENEFIT Benefits shall be provided on the same basis as any other Sickness for Covered Persons for the expenses incurred for screening for lead poisoning.

MATERNITY, CHILDBIRTH, WELL-BABY AND POST PARTUM CARE BENEFIT Benefits shall be provided on the same basis as any other Sickness when the Covered Person incurs an expense for prenatal care, childbirth and post-partum care. Benefits shall be provided for a minimum of forty-eight (48) hours of in-patient care following a vaginal delivery and a minimum of ninety-six (96) hours of in-patient care following a cesarean section for a mother and her newly born child

including routine well-baby care. Any decision to shorten such minimum stay shall be made by the attending Physician in consultation with the mother. Any such decision shall be made in accordance with rules and regulations promulgated by the Department of Public Health. Said regulations shall be relative to early discharge, defined as less than forty-eight (48) hours for a vaginal delivery and ninety-six (96) hours for a cesarean delivery, and post-delivery care and shall include, but is not limited to, home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit shall be conducted by a Physician. Additional Medically Necessary home visits shall be provided upon recommendation by a Physician.

Benefits shall also be provided on the same basis as any other Sickness for Medically Necessary special medical formulas which are approved by the commissioner of the Department of Public Health, when prescribed by a Physician to protect the unborn fetuses of pregnant women with phenylketonuria.

MENTAL DISORDERS TREATMENT BENEFIT

Benefits shall be provided on the same basis as any other Sickness for the Covered Person for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, referred to in this benefit as the "DSM": schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the Department of Mental Health in consultation with the commissioner of the Division of Insurance.

Benefits shall be provided on the same basis as any other Sickness for the Covered Person for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, as defined by sections 22 and 24 of chapter 265, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant to subparagraph (C) of paragraph (2) of subsection (b) of section 3 of chapter 258C.

Benefits shall be provided on the same basis as any other Sickness for covered Dependent children under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by a Physician, or is evidenced by conduct, including, but not limited to: an inability to attend school as a result of such a disorder, the need to hospitalize such child as a result of such a disorder, or a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

Such benefits to a Dependent child who is engaged in an ongoing course of treatment shall continue beyond the Dependent's nineteenth birthday until said course of treatment, as specified in such child's treatment plan, is completed and while the Policy under which such benefit first became available remains in effect, or subject to a subsequent Policy which is in effect. Benefits shall be provided on the same basis as any other Sickness for the Covered Person for Medically Necessary treatment for the diagnosis and treatment of all other mental disorders not otherwise provided for in this benefit section and which are described in the most recent edition of DSM during each 12 month period on the following basis: up to 60 days of inpatient treatment; and up to 24 outpatient visits.

Benefits shall be provided on the same basis as any other Sickness for the Covered Person for Medically Necessary treatment of alcoholism or chemical dependency when said treatment is rendered in conjunction with treatment for mental disorders pursuant to this benefit section.

Such benefits shall include inpatient, intermediate, and outpatient services that are Medically Necessary and active and non-custodial treatment for such mental disorders to take place in the least restrictive clinically appropriate setting. For purposes of this benefit, inpatient services may be provide in a general Hospital licensed to provide such services, in a facility under the direction and supervision of the Department of Mental Health, in a private mental Hospital licensed by the Department of Mental Health, or in a substance abuse facility licensed by the Department of Public Health. Intermediate services shall include, but are not limited to, Level III community-based detoxification, acute residential treatment, partial

hospitalization, day treatment and crisis stabilization licensed and approved by the Department of Public Health or the Department of Mental Health. Outpatient services may be provided in a licensed Hospital, a mental health or substance abuse clinic licensed by the Department of Public Health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Benefits shall be provided on the same basis as any other Sickness for the Covered Person for Medically Necessary psychopharmacological services and neuro-psychological assessment services.

When necessary for administration of claims under this benefit section, consent to the disclosure of information regarding services for mental disorders will be required on the same basis as disclosure of information of other Sickness or Injury.

Benefits will not be payable for mental health benefits or services: which are provided to a person who is incarcerated, confined or committed to a jail, house of correction or prison, or custodial facility in the department of youth services within the Commonwealth or one of its political subdivisions; which constitute educational services required to be provided by a school committee pursuant to section 5 of chapter 71B; or which constitute services provided by the Department of Mental Health.

Licensed Mental Health Professional mean a Physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

OFF-LABEL DRUG USE BENEFIT If benefits are payable for Prescription Drugs under this Policy (see Schedule of Benefits) then benefits will be payable on the same basis as for any other Prescription Drug for any drug prescribed to treat the Covered Person for cancer or HIV/AIDS if the drug is recognized treatment for the indication in one of the standard reference compendia or in the medical literature.

Standard reference compendia means (a) the United States Pharmacopeia Drug Information; (b) the American Medical Association Drug Evaluations; or (c) the American Hospital Formulary Service Drug Information.

Medical literature means published scientific studies published in any peer-reviewed national professional journal. Benefits shall also include Medically Necessary services associated with the administration of the drug.

For such Prescription Drugs that are payable due to establishment by the commissioner as payable after a review of the panel of medical experts as outlined in Massachusetts Insurance code, 175:47L, benefits shall be payable for the treatment of cancer for such drugs that are not included in any of the standard reference compendia or in the medical literature.

Benefits shall include coverage for Medically Necessary services associated with the administration of such drugs.

SCALP HAIR PROSTHESIS BENEFIT Benefits shall be provided on the same basis as any other Sickness for expenses for scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia when a written statement by a Physician is furnished stating that the scalp hair prosthesis is Medically Necessary. Benefits are limited to \$350.00 per Policy Year maximum.

SPEECH, HEARING AND LANGUAGE DISORDERS TREATMENT: Upon proof the Covered Person is diagnosed and treated for speech, hearing or language disorders by a Physician, we will pay the benefit as any other Sickness. Benefit shall be payable for services provided in a hospital, clinic or Physician's office. Such coverage shall not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting.

HYPODERMIC SYRINGES OR NEEDLES BENEFIT - Benefits will be payable on the same basis as any other Sickness for Medically Necessary hypodermic syringes or needles.

PROSTHETIC DEVICES BENEFIT Prosthetic Devices Benefits shall be provided for Covered Persons for the expense incurred for a Prosthetic Device. Benefits will be paid on the same basis as any other durable medical equipment covered under this Policy and will be limited to the most appropriate model that adequately meets the Covered Person's medical needs, as determined by his treating Physician. Repairs and replacements of Prosthetic Devices are also covered, subject to any Coinsurance requirements or Deductibles, unless necessitated by misuse or loss.

For the purposes of this benefit the following definition has been added:

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

This Policy will not impose any annual or lifetime dollar maximum on coverage for Prosthetic Devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under this Policy.

This Policy will not apply amounts paid for Prosthetic Devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under this Policy.

This Policy may include a reasonable Coinsurance requirement for prosthetic devices and repairs, not to exceed 20 percent of the allowable cost of the Prosthetic Device or repair, unless all covered benefits applying Coinsurance under the plan do so at a higher amount. If such policy provides coverage for services from nonparticipating providers, the contract may include a reasonable Coinsurance requirement for Prosthetic Devices and repairs, not to exceed 40 per cent of the allowable cost of the device or repair when obtained from a nonparticipating provider, unless all covered benefits applying Coinsurance under the plan do so at a higher amount.

Benefits are subject to such Deductible and Coinsurance amounts as shown on the Schedule of Benefits for Injury or Sickness.

All of the above benefits shall be subject to all Deductibles, coinsurance, copayments, limitations and any other Policy provisions.

LIMITATIONS AND EXCLUSIONS

Benefits will not be paid under the plan for expenses, which result from:

1. Riding as passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airplane. This exclusion does not apply to insured students while taking flight instructions for School credit;
2. Eyeglasses, radial keratotomy, contact lenses, hearing aids, or prescriptions or examinations except as required for repair caused by a covered Injury;
3. Cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an injury which necessitates medical treatment within 24 hours of

the accident. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of the Policy;

4. Elective abortion;
5. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
6. Injury or Sickness for which benefits are payable under any Worker's Compensation or Occupational Disease Law;
7. Declared or undeclared war, riot, civil disorder, civil commotion or acts of terrorism;
8. Committing an assault or felony; or fighting, except in self-defense;
9. Injury sustained or Sickness contracted while in the service of the armed forces of any country. When the Covered Person enters the armed forces, we will refund any unearned pro-rata premium with respect to such person;
10. Expenses for preventative medicines, vaccines (except antitoxins administered within 24-hours after an accident), or prescription drugs, or prescription drugs, or injections administered during an outpatient visit, except an injection given by a Physician in private practice who will certify that a Medical Emergency was required for the condition, unless specifically covered elsewhere in the Policy;
11. Dental treatment except as specifically provided for treatment resulting from Injury to natural teeth;
12. Alcohol intoxication as defined in the state where the accident occurred;
13. Services that are provided normally without charge by the School's health center, infirmary or Hospital; or by any person employed by the School;
14. Routine screenings or test which are not Medically Necessary for the diagnosis or treatment of your condition or which are not specifically ordered by the admitting Physician (except as stated in the Mandated Benefits Section of this Policy);
15. Elective Surgery or Elective Treatment;
16. Expenses in excess of \$1,000 in connection with Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate or interscholastic sport, contest or competition sponsored by the College, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant.

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the six months immediately prior to his Effective Date of Coverage under the Policy. Routine follow-up care to determine whether a breast cancer has re-occurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advise or treatment for purposes of this section unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a pre-existing condition.

Covered Medical Expenses resulting from a Pre-existing condition will not be covered unless:

- (1) six consecutive months have elapsed during which no medical treatment or advice is given by a physician for such condition; or
- (2) the Covered Person has been insured under the Policy and the School's prior policies for one year; or
- (3) the Covered Person has been receiving benefits under the School's prior policies and has been continuously insured since the date of accident, Injury or Sickness, whichever occurs first; or
- (4) the Insured had Qualifying Previous Coverage. If the Insured had Qualifying Previous Coverage the Pre-existing Condition limitation will be reduced by the number of months covered under the Qualifying Previous Coverage.

NON-DUPLICATION OF BENEFITS

The Policy provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by any other valid and collectible insurance. If the Covered Person is covered by other valid and collectible insurance, all benefits payable by such insurance will be determined before benefits will be paid by the Policy. The Policy is the second payor to any other insurance having primary status or no coordination or non-duplication of benefits provision.

If the Covered Person is insured under group or blanket insurance, which is also excess to other coverage, the Policy pays a maximum of 50% of the benefits otherwise payable.

UTILIZATION REVIEW PROGRAM

If a claim is denied payment due to lack of Medical Necessity, the Covered Person may appeal the decision. Send a written appeal to the Plan Administrator at Bollinger, Inc., P. O. Box 727, Short Hills, NJ 07078-0727. Include in the written appeal any additional information or evidence the Covered Person may have regarding the claim.

The appeal will be sent to an independent utilization review organization for review. Written notification of the decision by the independent utilization review organization will be sent to the Covered Person within 30 days of the appeal receipt date.

If the first appeal is denied, a second appeal may be submitted to the Office of Patient Protection within 45 days of the Covered Person's receipt of the written decision. Procedures for filing a grievance with the Office of Patient Protection begins on page 22 of this brochure. The procedures for filing the appeal are the same as the first appeal. All new information or evidence regarding the Medical Necessity of the claim should be submitted for review.

You may contact Bollinger, Inc. at 1-800-526-1379 to determine the status or outcome of the utilization review decision.

GRIEVANCE PROCEDURES

INTERNAL INQUIRY PROCESS -After receiving the notice of an adverse determination an insured may call the Claims Administrator with questions or concerns. The Claims Administrator shall attempt to answer questions and resolve the concerns to the Covered Person's satisfaction. The Claims Administrator shall do so within three business days.

A copy of the following internal inquiry process shall be provided to the Covered Person who has inquired:

“ A Covered Person is encouraged to submit its specific question or concern and any applicable thoughts or reasoning to the Claims Administrator at Bollinger, Inc. either by phone at 866-267-0092 or by mail to P.O. Box 727, Short Hills, NJ 07078-0727, or by email to Jane.Farrell@BollingerInsurance.com. The Claims Administrator shall acknowledge the inquiry with a response via the mode received. This inquiry will be reviewed and if necessary investigated by an individual who is appropriate for the question of concern conveyed by the Covered Person. The Covered Person's inquiry will be addressed in writing within three business days. That written communication will, 1) convey the results of the Company's efforts to address the inquiry, 2) ask the Covered Person to consider whether the Company has responded to the inquiry to his/her satisfaction, and 3) if that answer is negative, advise the

Covered Person of his/her rights to utilize the Company's internal grievance process, and 4) have any oral inquiry and the Company's subsequent actions and response reduced to writing. The Claims Administrator shall keep records of each inquiry for at least two years."

However, if a Covered Person contacts the Claims Administrator after an adverse determination concluding that Services provided were not medically necessary and the purpose of that contact is to appeal or object to the Company's adverse determination, the Claims Administrator shall begin to treat this as part of the grievance process.

GRIEVANCES AND APPEALS OF DENIALS BASED ON LACK OF MEDICAL NECESSITY

1st LEVEL - If the claim is denied payment again due to lack of Medical Necessity, the Covered Person may appeal the decision and the file will be reviewed by Avidyn an independent third party review organization. The Covered Person shall submit an appeal request or grievance to the Claims Administrator at Bollinger, Inc. This may be presented by telephone to 866-267-0092, by mail to P.O. Box 727, Short Hills, NJ 07078-0727, or by email to Jane.Farrell@BollingerInsurance.com.

If the appeal or grievance is made orally via telephone, it shall be reduced to writing by the Claims Administrator who shall forward a copy of that writing, including an acknowledgement of the grievance and an authorization form, within 48 hours to the Covered Person, the Company, and Avidyn within 48 hours. Otherwise, a written acknowledgement of the grievance including a statement advising the Covered Person of his/her right to appear before Avidyn's Utilization Review Organization's appeals panel or have his physician do so on his behalf, and an authorization form allowing the release of medical records and information shall be sent to the Covered Person for his/her signature within fifteen days of receipt of notice of the grievance or appeal.

In addition, the Covered Person should submit with the written appeal or grievance any additional information or evidence the Covered Person wants considered regarding the adverse claim determination. The Claims Administrator shall notify the Company of the appeal, and acknowledge the appeal in writing by sending a letter back to the Covered Person.

All necessary information and documentation and the request for review due to the appeal will be sent to Avidyn, the independent Utilization Review Organization, currently, for a medical necessity determination. All decisions and determinations will be made by an appropriately licensed physician and will be honored by the Company.

Written notification of the decision by Avidyn will be sent to the Covered Person within 30 days of the appeal receipt date. If a review of medical records is required, the 30 day period does not begin until a signed authorization is received.

If Avidyn determines the Services were medically necessary the claim is processed according to the terms of the plan and a payment is processed and issued. The Explanation of Benefits (EOB) attached to the payment gives the claimant an explanation of what benefits were paid.

If Avidyn determines the Services were not medically necessary the denial is upheld. The written resolution is issued the Covered Person and shall include a clear description of the substantive clinical justification for the adverse medical necessity determination, and shall at a minimum: 1) identify the specific information upon which the adverse determination was based; 2) discuss the Covered Person's presenting symptoms or conditions, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; and 3) reference and include applicable clinical practice guidelines and review criteria.

The written resolution shall also notify the Covered Person (or an authorized representative) of the procedures for requesting a review with the State Office of Patient Protection and a copy of the appropriate form used by the OPP to request an external review if denial of the claim based on medical necessity is upheld.

APPEAL TO THE OFFICE OF PATIENT PROTECTION OR 2nd LEVEL APPEAL

The Covered Person may at any time file an appeal with the Office of Patient Protection. If the Covered Person files an appeal with the Office of Patient Protection the ruling or decision of the Office of Patient Protection will govern.

If the Covered Person chooses to first appeal through the company's appeal procedures and the first and second appeals are denied, an additional appeal may be submitted to the Office of Patient Protection within 45 days of the Covered Person's receipt of the written decision. The procedures for filing the appeal are those of Office of Patient Protection. All new information or evidence regarding the Medical Necessity of the claim should be submitted to the Office of Patient Protection for review. The medical necessity determination made by the Office of Patient Protection will govern.

OFFICE OF PATIENT PROTECTION OF THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

The Office of Patient Protection is available to assist the Covered Person with Grievances and may also answer questions concerning new legislation or regulations under the authority of such office. The Covered Person may contact the Office of Patient Protection at the following toll-free telephone number, facsimile number, or web-site address:

Toll-Free: 1-800-436-7757

Facsimile: (617) 624-5046

Web-site:www.state.ma.us/dph/opp

The Office of Patient Protection requires carriers to file Grievance and external appeals information annually. You can obtain a copy of this information by contacting the Office of Patient Protection.

INTERPRETER AND TRANSLATION SERVICES ENGLISH

"Interpreter and Translation Services Available"

We provide, upon request, interpreter and translation services related to administrative procedures and claim processing. This service is available to a Covered Person by contacting our Administrator, Bollinger, Inc., at 1-866-267-0092

PORTUGUESE

"Serviços de Interpretação e Tradução Disponíveis"

Nós fornecemos, a pedido, serviços de tradução e interpretação relacionados aos procedimentos administrativos e de processamento de faturas médicas. Este serviço está disponível a pessoas cobertas contatando nossos Administrador, Bollinger, Inc., fone 1-866-267-0092

FRENCH

Service d'interprétation et de traduction proposé

Nous proposons un service d'interprétation et de traduction lié aux procédures administratives et à la gestion des réclamations. Ce service est mis à la disposition des personnes assurées qui peuvent en faire la demande en contactant notre administrateur, Bollinger, Inc au 1-866-267-0092.

SPANISH

"Tenemos disponible servicios de Interprete y Traducciones en Español"

A petición, proveemos servicios de interpretación y traducción relativo al procedimiento administrativo y proceso de reclamos medico. Este servicio está disponible a las personas a seguras con solo contactar a nuestro administrador, Bollinger, Inc. al 1-866-267-0092.

ITALIAN

Noi provvediamo, su, richiesta, interprete e servizi di traduzione relativi alle procedure amministrative ed elaborazione di reclami.. questi servizi sono a disposizione di una persona coperta mettendosi in contatto con il nostro Administrator, Bollinger, Inc., a 1-866-267-0092.

GERMAN

Interpretations- und Uebersetzungservice

Wir bieten auf Anfrage Interpretations- und Uebersetzungsservice im Bezug zu administrativen Verfahren und Anspruchsverfahren an. Dieser Service ist verfuegbar fuer versicherte Personen indem sie unseren Anbieter Bollinger Inc. unter 1-866-267-0092. kontaktieren.

GREEK

Μεταφρασεις Κειμενου Διαθεσιμη

Μεταφρασεις Κειμενου Διαθεσιμη

Προφερουμε απο επιθιμια σας, μεταφρασεις κειμενου που αφορουν διαχειριστικα θεματα και ασφαλειας. Αυτι η προσφορα ειναι διαθεσιμη για ασφαλισμενους. Για περισσοτερες πληροφοριες επικοινωνιστε με εναν αντιπροσωπο του Bolinger , Inc. στις 1-866-267-0092

RUSSIAN

Услуги в области устных и письменных переводов

По вашим запросам, мы предоставляем услуги в области устных и письменных переводов, относящихся к административным процедурам и к обработке страховых требований. Эти услуги предоставляются застрахованным лицам, и их можно заказать через нашего Администратора, компанию Bollinger, Inc., позвонив по телефону 1-866-267-0092

HATIAN-CREOLE

Nou bay sèvis entèprèt ak tradiksyon"

Nou bay sèvis entèprèt ak tradiksyon pou pwosede administrative ak pou nou ak pou fè aplikasyon, si yon moun mande sa. Sèvis sa a la tou pare pou moun ki kouvri si moun nan kontakte Administratè, Bollinger, Inc. nou an nan 1-866-267-0092.

ARABIC

قرصوت م قيط ل او قيوفش ل ا قم جرت ل ا تامد

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0092-267-800-1

CAMBODIAN

មានអ្នកបែកសា និង កិច្ចការដែលសំរាប់បែកសា

យើងមានអ្នកបែកសា សំរាប់បំបែកម្ហូបស្លឹក និងកិច្ចការដែលបែកសាទាក់ទង
ទៅនឹងការបាត់បង់អំពីទំនាក់ទំនងរបៀបតវ៉ាខ្មែរមនុស្សរដ្ឋប្បវេណី។ តួអង្គកិច្ចការនេះ
ទៅអ្នកបំបែកការ ដោយសូមជ្រើសរើសទាក់ទងមកអ្នកបាត់ការនៃកុមហ្វូន បូលីង
តាមទូរស័ព្ទលេខ ១-៨០០-៥២៦-១៣៧៩

LAO

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ເມື່ອໄດ້ມີການຮ້ອງຂໍ, ເຮົາຈັດຫາບໍລິການແປພາສາລະແປເອກະສານກ່ຽວກັບຂັ້ນຕອນຕ່າງໆ ດ້ານການ
ບໍລິຫານແລະການພິຈາລະນາຄໍາອ້າງສິດທິ. ບໍລິການນີ້ມີໄວ້ສໍາຫລັບບຸກຄົນທີ່ຖືປະກັນພັນ ແລະສາມາດຮັບ
ໄດ້ໂດຍຕິດຕໍ່ຜູ້ບໍລິຫານຂອງເຮົາ ຄື ບໍລິສັດ **Bollinger, Inc.**, ທີ່ເລກໂທ 1-866-267-0092

CHINESE

我提供口?和??服?。

我可按客?需要提供有?行政程序和保?索??理的各??言口?和??服?。?迎受保
人向 **Bollinger 公司??代表洽?**, ?? : 1-866-267-0092

STUDENT HEALTH CENTER

The College of the Holy Cross provides a Student Health Center for the benefit and convenience of enrolled students. The Student Health Center is not a preferred provider under this Plan. However, the College of the Holy Cross strongly encourages students to use the Student Health Center when first seeking non-emergency treatment, therefore it is the College’s policy to provide medical treatment at the Student Health Center at a reduced charge or no charge to the Covered Person.

Health Services hours during the academic year:

Monday – Friday: 8:30 AM – 5:30 PM
Saturday & Sunday: 10:00 AM – 4:00 PM

Health Services hours during the non-academic year:

Monday – Friday: 8:30 AM – 4:30 PM
Phone: (508) 793-2276

OBTAINING MEDICAL CARE/FILING CLAIM

In the event of an Injury or Sickness the student should:

1) If at school in a non-emergency situation, report immediately to the Student Health Center.

2) If away from school, obtain the appropriate claim form from the school, or Plan Administrator as soon as possible.

Claim forms are available from the web site:

www.BollingerColleges.com/HolyCross

3) CLAIM FORMS ARE REQUIRED ONLY FOR CLAIMS WHICH EXCEED \$250.

EMERGENCY SERVICES

In the event of an Emergency Medical Condition, a Covered Person has the option of calling a local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever a Covered Person is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services.

All claims must be submitted to Bollinger, Inc. within 30 days from the date of loss. Attach all available bills at that time. If they are not available send them in at a later date, properly identifying them with the name of the student and school.

CLAIM PROCEDURE

In the event of either an Injury or Sickness, claims must be reported by the Covered Person directly to:

Bollinger, Inc.

P.O. Box 727

Short Hills, NJ 07078

1-866-267-0092

within 30 days from the date of Injury or first treatment for Sickness. Medical bills must be submitted within 90 days from the date of treatment. We will pay benefits to you or a parent when a receipted bill is submitted for a covered claim. When benefits are assigned, they will be paid directly to the provider of hospital-medical care. Claim forms may be obtained from the college, if at college, or from the Plan Administrator when away from college.

If payment is not made within 45 days of proof of loss, you will be notified in writing with the reasons for non-payment or whatever further documentation is needed for payment of said claims.

PATIENT PRESCRIPTION DRUG BENEFIT

Prescriptions filled at a Caremark Pharmacy: after a \$5 co-pay for each prescription, the cost of prescription medications is payable up to \$500 per Insured individual for the Policy year. Insured person(s) will receive an ID card to use at the pharmacy. When obtaining a covered prescription, please present your Caremark Pharmacy ID card to the pharmacy. Caremark will bill Bollinger, Inc. for the cost of the drug, plus a dispensing fee. When you need to fill a prescription and do not have your ID card with you, you may obtain your prescription and be reimbursed by submitting a completed claim form with the receipt(s) attached to Bollinger, Inc. at P.O. Box 727, Short Hills, NJ 07078-0727. You will be reimbursed for covered medications directly by Bollinger, Inc. You will be able to purchase up to a 30 day supply at the retail pharmacy. Not all medications are payable. The following is a partial list of those excluded: acne treatment, and vitamins. A complete list of exclusions is shown in the Master Policy, which is on file with the school.

STUDENT ASSISTANCE SERVICES

(Administered by On Call International)

Nurse Advise Line: On Call shall provide Students enrolled in this Plan with clinical assessment, education and general health information. This service shall be performed by a registered Nurse counselor to assist in identifying the appropriate level and source(s) of care for Students (based on symptoms reported and/or health care questions asked by or on behalf of Students). Nurses shall not diagnose a Student's ailments.

Travel Assistance Services: Each Insured Student and his/her enrolled Dependents are eligible for travel assistance services when traveling 100 miles or more away from their home and campus address. Travel Services are only available for medical claims that are covered under the College's Student Accident and Sickness Insurance Plan. Services provided include: Emergency Medical Transportation (Evacuation/Repatriation); Medical Monitoring; Medical, Dental, & Pharmacy Referrals; Deposit, Advance, & Payment Guarantees; Dispatch of Medicine, Physician, or Nurse; Return of Deceased Remains; Return of Minor Children Assistance; Pre-Trip Information; 24/7 Emergency Travel Arrangements; Translation Assistance; Emergency Travel Funds Assistance; Worldwide Legal Assistance; Lost/Stolen Travel Documents Assistance; Emergency Message Forwarding; and Lost Luggage Assistance.

Bedside Visit: In the event that a covered student will be hospitalized 7 days or longer, On Call International will provide a benefit of up to \$2,500 for a parent or family member to join the hospitalized student. The benefit can go towards transportation and accommodations. In all cases On Call International must make and pay for the travel and accommodations arrangements. There is no reimbursement for transportation or accommodations if made by the family or school.

Emergency Return Home: If a parent or sibling of a covered student dies or is hospitalized for a life threatening illness while the student is away at school (100 miles or more), On Call International will provide a benefit of up to \$2,500 for the student to return home. In all cases On Call International must make and pay for the travel arrangements. There is no reimbursement for transportation if made by the student, family or school.

Identity Theft Recovery Assistance: In the event that a covered student suspects he or she is a victim of identity theft, the student may contact On Call International to speak to the Identity Theft Recovery Unit. The Identity Theft Recovery Unit is a team of trained Fraud Specialists who will listen, document, and support participants who experience identity theft. The Fraud Specialist will: obtain participant's permission to pull and review their 3-bureau credit report in detail, with the participant; enroll the customer in six months of daily credit bureau monitoring to monitor and detect suspicious activity; document the event and contact history with participant; at participant request, assist in the placement of Fraud Alerts with major credit reporting agencies; write dispute letters on behalf of participant for signing and forwarding to National Credit Bureaus and Creditors. The Identity Theft Recovery Unit provides victims with a Fraud First Aid Kit which includes: Tips for Fraud Victims; Credit Bureau Reporting Agency Information; Contact History Tracking; Pre-populated letters to creditors to dispute suspicious items.

U.S. & Canada Toll Free: 866-525-1955
International Collect: 603-328-1955

Note: The On Call related services listed above are not insurance and are not connected with or provided by Monumental Life Insurance Company.

For Information contact the Plan Administrator

Bollinger
Insurance Solutions

P. O. Box 727
Short Hills, NJ 07078-0727
1-866-267-0092 (Claims/Coverage)
1-800-526-1379 (Other Questions)

www.BollingerColleges.com/HolyCross

This Plan is Underwritten by:
MONUMENTAL LIFE
INSURANCE COMPANY
Cedar Rapids, Iowa

Preferred Provider Network

 **First Health**
Network

PLEASE KEEP THIS BROCHURE AS A GENERAL SUMMARY OF THE INSURANCE BENEFITS. The Master Policy on file at the School contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. If any discrepancy exists between the Brochure and the Master Policy, the Master Policy will govern and control the payment of benefits.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Policy Form: SH5000GPM.MA

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