

Student Injury and Sickness Evidence of Coverage Brochure 2012-2013

Designed for the Students of



SALTERcollege

This health plan satisfies Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Underwritten By:
**Monumental Life
Insurance Company**
Cedar Rapids, Iowa
(an AEGON company)

**Effective from 01/10/12 through 01/09/13
Policy Number: CMA812I**

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.

This outline of coverage is intended only for quick reference and does not limit or amplify the coverage as described in the Master Policy which contains complete terms and provisions. The Master Policy is on file at the College. The intent of the policy is to pay according to the minimum mandated benefits accorded by law.

To Students And Parents

The College has implemented a Student Injury and Sickness Plan. The Plan is designed to provide protection against unexpected and frequently heavy expenses for Injury or Sickness.

Students should carefully review coverage to insure that the coverage meets their needs. Please be aware that there are stringent time deadlines for submission of claim forms. It is recommended that students retain this brochure for reference purposes.

ELIGIBILITY

All students enrolled for a minimum of 9 credit hours are included in this insurance plan and the premium for coverage is added to the tuition billing unless proof of comparable coverage is furnished at the time of registration.

TERMS OF COVERAGE AND COST

The Master Policy for the current year becomes effective on January 10, 2012 at 12:01 a.m. and expires on January 10, 2013 at 12:00 a.m. Coverage remains in effect during holiday and vacation periods. Should an Insured person graduate or withdraw from the institution, the insurance shall remain in effect until the end of the period for which premium has been paid.

Eligibility periods will be broken into quarters beginning 01/10/12, 04/10/12, 07/10/12 and 10/10/12. Students beginning school at anytime in the first quarter would pay for annual coverage at a rate of \$900. Students beginning anytime in the second quarter would pay \$722. Students beginning anytime in the third quarter would pay \$545. Students beginning anytime in the fourth quarter would pay \$367. Please note that the above rates include an administrative fee.

Students who begin school later in a quarter will have the option of waiting until the next quarter to purchase the coverage. Coverage for each student will begin the later of the date they start school or the date of the quarter for which they paid the premium. Coverage for all students will expire on January 10, 2013.

Students whose courses will end during the first few weeks of the first quarter following this year's policy termination date, will be allowed to purchase coverage for the full year at the rate offered for that policy year OR can purchase coverage for the first quarter only, at a quarter of that year's policy premium.

DEFINITIONS

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 Schedule;(2) in excess of any deductible amount; and (3) incurred while the Covered Person's coverage under this Policy is in force.

COVERED PERSON means an eligible student as outlined in this Policy for whom an application has been received and for whom the required premium has been paid. The words he, his, and him refer to the Covered Person, regardless of gender.

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 this Policy.

Elective Surgery and Elective Treatment includes but is not limited to surgery and/or treatment for acne; acupuncture; 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 this 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 this Policy;

deviated nasal septum, including submucous resection and/or other surgical correction; hair growth or removal; learning disabilities except for prescription drugs prescribed for such disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind except for screening, counseling or behavioral interventions prescribed for the treatment of obesity), except for the treatment of an underlying covered Sickness; premarital examinations; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction (TMJ); tubal ligation; vasectomy; and weight loss or reduction.

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under this Policy. A Covered Person must begin receiving services, supplies or treatment within 72 hours 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 these Injuries, are considered a single covered Injury. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

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 Covered Person 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.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts, including chiropractor, optometrist, certified registered nurse anesthetist, nurse practitioner, certified nurse midwife and dentist. He must be practicing within the scope of his license for the service or treatment given.

He may not be the Covered Person or a member of his Immediate Family.

SICKNESS means an illness, or disease which causes a loss while this Policy is in force 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 and Complications of Pregnancy.

BASIC PLAN COVERAGE

Basic Injury and Sickness Expense Benefits: We will pay benefits for those Covered Expenses incurred by the Covered Person for Injury sustained or Sickness commencing while insured under this Policy. Benefits are subject to an aggregate maximum of \$50,000 per Injury or Sickness. Covered Medical Expenses include the following:

Hospital Room and Board Expense: When you require hospital confinement, we will pay the hospital room and board Expense up to 80% of the semi-private or intensive care unit rate.

Miscellaneous Hospital Expense: We will pay 80% of the Expense incurred by you during a hospital confinement or as an outpatient for day surgery. We will pay for anesthesia, operating room, laboratory test, x-rays, oxygen tent, drugs, medicines, dressings, and other necessary non-room and board hospital expenses.

Surgical Expense (Inpatient & Outpatient): When you require surgery, we will pay 80% of the Expense to a maximum of \$5,000 per Injury or Sickness. If surgery requires the services of an anesthetist, who is not employed or retained by the hospital in which the operation is performed, we will pay up to 30% of the amount payable for the operation. If the surgery requires the services of an Assistant Surgeon, we will pay up to 30% of the amount payable for the operation.

In-hospital Physician's Fees Expense: when you require the services of a Doctor, other than the surgeon, we will pay 80% of the Expense for such services.

Ambulance Expense: When you require the use of an ambulance, we will pay the Expense up to \$500 per Injury or Sickness.

Outpatient Expense: When you require Medically Necessary services provided in a Doctor's office, hospital

or outpatient department or emergency room, clinical lab, radiological facility or other similar licensed facility, we will pay 80% of the Expense up to the maximum benefit of \$2,500 per Injury or Sickness, subject to the following co-pays:

- Hospital emergency room visit does not result in an admission, the co-pay will be \$100.
- Hospital emergency room visit that does not result in an admission, when doctor ordered, the co-pay will be \$50.
- Hospital outpatient department visit co-pay will be \$50.
- Doctor visit co-pay will be \$25.

Deductible and Coinsurance will also be waived for emergency medical services for an Injury or Sickness which, if not treated at once, would place your life in danger. Physical Therapy/Chiropractic care is included in this benefit provided it is prescribed by a licensed physician and such prescription for a stated number of treatment. For any additional such treatment, the referring physician must issue a new prescription following medical re-evaluation of the Insured's condition.

High Cost Procedure Expense: In addition to the coverage above, for specific outpatient services costing over \$200 (C.A.T. scan, magnetic resonance imaging, laser treatment) we will pay 80% of the Expense up to a maximum benefit of \$2,000 per Injury or Sickness.

Consultant or Specialist Expense: When you require the services of a consultant or specialist to confirm or determine a diagnosis, we will pay the Expense up to a maximum benefit of \$300 per Injury or Sickness.

Prescribed Medicine Expense: When you require prescription medications ordered by the attending Doctor, we will pay 80% of the Expenses up to a maximum benefit of \$50 per Injury or Sickness, after a \$5 co-pay.

Maternity Expense: Expenses for pregnancy including complications are covered to the same extent coverage is provided for any other Sickness. Voluntary abortion is payable at 100% up to \$400.

Birth Control: Outpatient Contraceptive Services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to pre-

vent pregnancy that have been approved by the United States Food & Drug Administration. Such outpatient contraceptive services shall be covered at 100% in-network. Out-of-network covered at Usual and Customary after any deductible or co-payment.

Annual Physical: Covered at 100% in-network; Usual and Customary out-of-network after deductible and co-payment.

Immunizations: Covered at 100% in-network; Usual and Customary out-of-network after deductible and co-payment.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this Policy ceases on the termination date. However, if a Covered Person is Hospital Confined on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date, Covered Medical Expenses for such Injury or Sickness will continue to be paid until the completion of his Hospital Confinement or as long as the condition continues for the duration of recovery but not to exceed 31 days from the expiration date of coverage or beyond release from the Hospital for that Inpatient Confinement or the maximum benefit per Injury or Sickness or whichever occurs first.

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 per Injury or Sickness.

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-existing Conditions for up to six months unless:

- (1) Up to 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 this Policy and the University's prior policies for one continuous year; or
- (3) The Covered Person has been receiving benefits under the University's prior policies and has been continuously insured since the date of Injury or Sickness, whichever occurs first.

- (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.

Pre-existing Conditions are defined as an Injury sustained or a Sickness for which the Covered Person was medically diagnosed, treated (including medication), or advised by a Physician within the six months immediately prior to his Effective Date of Coverage under this Policy or a pregnancy existing on the Effective Date of Coverage. No Pre-Existing Condition limitations will be imposed upon a Covered Person under 19 years of age.

Qualifying Previous Coverage means coverage of the Covered Person under any of the following: 1) An employee sponsored plan; 2) health benefit plan; 3) Part A or Part B of Title XVIII of the Social Security Act; 4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; 5) Chapter 55 of Title 10 of the United States Code; 6) a medical care program of the Indian Health Service or of a tribal organization; 7) a state health benefits risk pool; 8) a health plan offered under the Federal Employees Health Benefits Program (FEHBP), Title 5, Chapter 89 of the United State Code; 9) a public health plan as defined by federal regulations authorized by the Public Health Service Act, §2701(c)(1)(i), as amended by P.L. 104-191; or 10) a health benefit plan under §5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a sixty-three day period during all of which the individual was not covered under any creditable coverage.

Any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period, shall not be taken into account in determining the period of creditable coverage.

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 multidisciplinary, 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 cytological 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.

DEPENDENT CHILDREN EARLY INTERVENTION SERVICES BENEFIT

Benefits shall be payable for Medically Necessary early intervention services for dependent children from birth to their third birthday including occupational, physical and speech therapy that are provided by a Physician or operational standards developed by the Department of Public Health; nursing care and psychological counseling that are provided by a Physician in accordance with an early intervention program approved by the Department of Public Health.

DEPENDENT CHILDREN PREVENTATIVE CARE BENEFIT

Benefits shall be payable for preventative care services for those preventive and primary services delivered or supervised by a Physician that are rendered to a dependent child of a Covered Person from the date of birth through the attainment of six years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment of the following intervals: six times during the child's first year after birth, three times during the next year, annually until age six. Such services shall also include hereditary and metabolic screening at birth, appropri-

ate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Physician. Benefits shall include those special medical formulas which are approved by the commissioner of the Department of Public Health, prescribed by a Physician, and are Medically Necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children.

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 treatment 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 HbA1c, 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 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.

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

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 if the female is age of 35 or younger or during a period of 6 months if the female is over the age of 35.

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

- A. Benefits shall be provided on the same basis as any other Sickness for Covered Persons 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":
- (1) schizophrenia;
 - (2) schizoaffective disorder;
 - (3) major depressive disorder;
 - (4) bipolar disorder;
 - (5) paranoia and other psychotic disorders;
 - (6) obsessive-compulsive disorder;
 - (7) panic disorder;
 - (8) delirium and dementia;
 - (9) affective disorders;
 - (10) eating disorders;
 - (11) post traumatic stress disorder;
 - (12) substance abuse disorders; and
 - (13) autism.

- B. Benefits shall be provided on the same basis as any other Sickness for a 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.
- C. Benefit 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:
- (1) an inability to attend school as a result of such a disorder,
 - (2) the need to hospitalize such child as a result of such a disorder, or
 - (3) 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.

- D. Benefit shall be provided on the same basis as any other Sickness for a 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:

- (1) Up to 60 days of inpatient treatment; and
- (2) Up to 24 outpatient visits.

Mental health benefits will be provided on a non-discriminatory basis to Covered Persons who are residents of the commonwealth and to all Covered Persons having a principal place of employment in the commonwealth for the diagnosis and medically necessary and active treatment of any mental disorder, as described in the most recent edition of the DSM, that is approved by the commissioner of mental health.

- E. Benefits paid under this section 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 proved 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.
- F. Benefit shall be provided on the same basis as any other Sickness for a Covered Person for Medically Necessary psychopharmacological services and neuropsychological assessment services.

- G. Benefit shall be provided on the same basis as any other Sickness for a Covered Person for pediatric specialty care, including, mental health care, by persons with recognized expertise in specialty pediatrics to Covered Persons requiring such 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.

Benefit 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 the 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 or HIV/AIDS 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.

PROSTHETIC DEVICES BENEFIT 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 the 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.

Definitions

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 the 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 the 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.

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.

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

PREFERRED PROVIDER NETWORK

This Student Injury and Sickness Insurance Plan provides access to Hospital and health care providers through the First Health Preferred Provider Network. The advantage to using a network provider is that these providers have agreed to accept a predetermined fee or Preferred Allowance as payment for their services. Non-network providers have not agreed to any prearranged fee schedule. Consequently, when Insured students use network providers, Out-of-Pocket Expenses will be less because any applicable Co-payment will be based on a Preferred Allowance. Regardless of the provider, you are responsible for the payment of your Deductible if applicable. You must satisfy your Deductible before benefits are paid. The Insured Person should be aware that network provider Hospitals may be staffed with non-network providers. Receiving services or care from a network provider Hospital does not guarantee that all charges will be paid at the network provider level of benefits. To determine if a provider participates in the First Health Network, students can go to www.BollingerColleges.com/salter and click on "Find a Doctor". It is important that Insured Students verify that his or her doctors are network providers when calling for an appointment or at the time of service.

REPATRIATION AND EVACUATION

Repatriation Expense Benefit: Upon receipt of due proof of a Covered Person's death, we will pay the Usual and Customary Charges for the preparation of the deceased's body for burial or cremation in the Home Country including the cost of embalming and coffin; and transportation of the deceased's body to his or her Home Country. The benefit payable is not to exceed \$7,500.

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 Usual and Customary Charges incurred not to exceed \$10,000 per Injury or Sickness, subject to the prior approval of the claims administrator for this Policy and the attending Physician.

EXCLUSIONS

Benefits will not be paid under this Policy and any attached Rider for any expenses, which result from:

1. Expenses incurred as the result of dental treatment, except as specifically provided for Covered Persons under age 19 and for treatment resulting from Injury to natural teeth;
2. Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except for Covered Persons under age 19 and except as required for repair caused by a covered Injury;
3. Declared or undeclared war, riot, civil disorder, civil commotion or acts of terrorism;
4. Committing or attempting to commit an assault or felony; or fighting, except in self defense;
5. 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 Injury. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Policy;
6. Injury resulting from racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
7. Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as fare-paying passenger in an aircraft operated by a commercial scheduled airline. This exclusion does not apply to insured students while taking flight instructions for University credit;
8. Injury sustained or Sickness contracted while in the service of the armed forces of any country;
9. Injury or Sickness for which benefits are payable under any Worker's Compensation or Occupational Disease Law;
10. Injury sustained or Sickness contracted as a re-

sult of the use of alcohol or the misuse of drugs, medicines, or narcotics, unless taken in the dosage and or the purpose prescribed by the Covered Person's Physician;

11. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
12. 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);
13. Elective Surgery or Elective Treatment.

CLAIM PROCEDURE

In the event of Injury or Sickness the student should:

1. Notify the Program Administrator (Bollinger, Inc) within 30 days after the date of the covered Injury or commencement of the covered Sickness or as soon thereafter as is reasonably possible.
2. Although your doctor may send the itemized bills to Bollinger, Inc. the student must submit the claim form directly to Bollinger, Inc. Written proof of loss (itemized bill(s)) must be furnished with your claim within 90 days after the date of the Loss.
3. Questions should be referred to Bollinger, Inc. at 1-866-267-0092.
4. All claims should be sent to:

Bollinger
Insurance Solutions

P.O. Box 727
Short Hills, NJ 07078-0727
1-866-267-0092

A claim must be submitted within 90 days after a Sickness or an Injury has occurred, in order for the claim to be paid.

CLAIMS WILL NOT BE CONSIDERED WITHOUT A PROPERLY COMPLETED CLAIM FORM.

Any provision of this policy, which on its effective date, is in conflict with the status of the state in which the policy is issued will be administered to conform with state law.

Inquiries regarding a benefit payment or denial can be made to Bollinger, Inc. either via the phone or in writing.

In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Bollinger, Inc.

- If a claim is denied payment for any other reason not related to Medical Necessity, the Covered Person may appeal the decision within 45 days of receipt of the claim denial and the file will be reviewed.
- If a claim is denied payment due to lack of Medical Necessity, the Covered Person may appeal the decision.

A written appeal should be sent 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.

If the appeal is for a Medical Necessity denial, it will be sent to an independent utilization review organization for review. Written notification of the decision 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, as well as interpreter and translation services, are set forth on the website: www.BollingerColleges.com/salter.

The procedures for filing the second 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 1-866-267-0092 to determine the status or outcome of the utilization review decision.

Complete information regarding the Monumental Life Utilization Review program, including full procedures for filing an inquiry, grievance or appeal can be ob-

tained at: www.BollingerColleges.com/salter. A paper copy of this information is available upon request from Bollinger, Inc.

**Underwritten By:
Monumental Life
Insurance Company**
Cedar Rapids, Iowa
(an AEGON company)

CLAIMS OFFICE

For questions regarding a claim or claims status:

Bollinger
Insurance Solutions

**P.O. Box 727
Short Hills, NJ 07078-0727
1-866-267-0092
www.BollingerColleges.com/salter**

STUDENT ASSISTANCE SERVICES

(administered by On Call International)

The following services are available for use by the students insured under this plan:

- Nurse Helpline
- Travel Assistance Services, including Bedside Visit and Emergency Return Home
- Identity Theft Recovery Assistance

For a description of these valuable services, please refer to our plan website, which is:

www.BollingerColleges.com/salter

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

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

