Student Injury & Sickness Insurance

Boston Baptist College
2013-2014

"Your student health insurance coverage, offered by Monumental Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. If you have any questions or concerns about this notice, contact Bollinger Inc., Short Hills, NJ, 1-866-267-0092. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information."

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
a Transamerica company

Please visit us on the web www.BollingerColleges.com/BostonBaptist

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 1-800-526-1379.

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

Policy Number: CMA817J

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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/BostonBaptist

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.

ELIGIBILITY

All full-time (12 credits or more) and qualifying part-time students are eligible. A part-time student is one who is participating in at least 75% of the academic requirements for full-time students.

All Eligible students will be enrolled in the Mandatory Basic Injury portion of the Plan. There is no option to waive this coverage.

All Eligible students will be automatically enrolled in a Student Injury and Sickness Insurance Plan, unless a completed Waiver Form, showing comparable coverage, has been received by the University by the specified Waiver Deadline Date.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. We maintain the right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever we discover that the policy eligibility requirements have not been met, our only obligation is refund of premium.

RATES

2013-2014	Annual rates 8/1/13 to 8/1/14	Spring Semester 1/9/14 to 8/1/14
Mandatory Basic Injury Plan	$80	$47
Sickness and Injury Plan		
Student Under Age 26	$1,886	N/A
Students Age 26 or Older	$2,613	

*Administration fee added to annual rate.

EFFECTIVE AND TERMINATION DATES

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2013. Coverage becomes effective on that date. The Master Policy terminates at 12:00 a.m. on August 1, 2014. 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.

Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a.m. on January 9, 2014 and will terminate at 12:00 a.m. on August 1, 2014.

WAIVER PROCESS

A waiver may only be granted for the combined Sickness and Injury portion of the Plan, not the Mandatory Basic Injury portion of the Plan.

If you have other insurance and do not wish to participate in the Sickness and Injury portion of the Plan, you must complete a Waiver Form stating that you have other comparable coverage and submit this waiver to the Boston Baptist College Business Office by the deadline below:

Category	Waiver Deadline Date
Annual Students	August 24, 2013
New Spring Students	January 11, 2014

DESCRIPTION OF BENEFITS

The Boston Baptist College Plan may not cover all of your health care expenses. The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read this brochure carefully before deciding whether this Plan is right for you.

All insurance companies and group health plans must use the same standard Summary of Benefits and Coverage ("SBC") form to help you compare health plans. You should review your SBC before enrolling in coverage by logging onto www.BollingerColleges.com/bostonbaptist. You may also request a copy from Bollinger by contacting them at 1-866-267-0092.

Mandatory Basic Injury Plan
All Eligible students enrolled at Boston Baptist College are protected for Covered Medical Expenses arising from accidental bodily Injury. This Plan provides payment for Covered Medical Expenses up to a Maximum of $2,000 per Injury.

Sickness and Injury Plan
This plan will pay up to an aggregate Maximum of $500,000 for Injury and Sickness benefits.

Benefits under the Mandatory Basic Injury Plan and the Sickness and Injury Plan are subject to the Summary of Benefits Chart below.

SUMMARY OF BENEFITS CHART

Inpatient Hospitalization Benefits	
Hospital Room and Board Expense	Preferred Care: 80% of the Negotiated Charge for a semi-private room. Non-Preferred Care: 80% of the Usual and Customary Charge for a semi-private room.
Pre-Admission Testing Expense	While an outpatient before scheduled surgery: Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge
Intensive Care Unit Expense	Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge for the Intensive Care Room Rate for an overnight stay
Miscellaneous Hospital Expense	Including but not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines. Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge
Physician Hospital Visit Expense	For the non-surgical services of the attending Physician or a consulting Physician Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge

Inpatient Hospitalization Benefits	
Licensed Nurse Expense	Benefits include charges incurred by a Covered Person who is confined in a Hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge
Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense	For charges for surgical services, performed by a Physician Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge
Anesthetist Expense	For the charges of an anesthetist, during a surgical procedure. Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge
Assistant Surgeon Expense	For the charges of an assistant surgeon, during a surgical procedure. Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge
Elective Surgical Second Opinion Expense	Covered Medical Expenses will include a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Preferred Care: After a $25 Co-pay per visit, 80% of the Negotiated Charge Non-Preferred Care: After a $25 Co-pay per visit, 80% of the Usual and Customary Charge.

Outpatient Benefits	
Emergency Room Expense	Preferred Care: After a $100 Co-pay (waived if admitted), 80% of the Negotiated Charge Non-Preferred Care: After a $100 Co-pay (waived if admitted), 80% of the Usual and Customary Charge
Chiropractic Care	Preferred Care: After a $25 Co-pay per visit, 80% of the Negotiated Charge Non-Preferred Care: After a $25 Co-pay per visit, 80% of the Usual and Customary Charge
Consultant or Specialist Expense	Covered Medical Expenses include the expenses for the services of a consultant or specialist. The services must be requested by the attending Physician for the purpose of confirming or determining to confirm or determine a diagnosis. Preferred Care: After a $25 Co-pay per visit, 80% of the Negotiated Charge Non-Preferred Care: After a $25 Co-pay per visit, 80% of the Usual and Customary Charge
Ambulance Expense	Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Usual and Customary Charge.
Hospital Outpatient Department or Walk-in Clinic Visit Expense	Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge
Therapy Expense	Preferred Care: After a $25 Co-pay per visit, 80% of the Negotiated Charge Non-Preferred Care: After a $25 Co-pay per visit, 80% of the Usual and Customary Charge
Physician's Office Visits	Preferred Care: After a $25 Co-pay per visit, 80% of the Negotiated Charge. Non-Preferred Care: After a $25 Co-pay per visit, 80% of the Usual and Customary Charge.
Laboratory and X-Ray Expense	Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge
High Cost Procedures Expense	Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge For purpose of this benefit, "High Cost Procedure" means any outpatient procedure costing over $200.
Durable Medical Equipment Expense	Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge

Outpatient Benefits	
Dental Injury Expense	Covered Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition: • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan. Any such teeth must have been: • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. If: • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, are installed due to such injury, Covered Medical Expenses include only charges for: • The first denture or fixed bridgework to replace lost teeth, • The first crown needed to repair each damaged tooth, and • An in-mouth appliance used in the first course of orthodontic treatment after the injury. Surgery needed to: • Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth. Covered Medical Expenses are payable as follows: up to a $500 maximum (Injury Only)
Impacted Wisdom Teeth Expense	Covered Medical Expenses for removal of one or more impacted wisdom teeth are payable as follows: Preferred Care: 80% of Actual Charge after a $25 copay Non-Preferred Care: 80% of Actual Charge after a $25 copay. Benefits are limited to $50 per tooth to an aggregate maximum of $200.
Allergy Testing Expense	Benefits include charges incurred for diagnostic testing of allergies and immunology services. Covered Medical Expenses include, but are not limited to, charges for the following: • Laboratory tests, • Physician office visits, including visits to administer injections • Prescribed medications for testing of the allergy, including any equipment used in the administration of prescribed medication, and • Other Medically Necessary supplies and services, Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge Non-Preferred Care: 80% of the Usual and Customary Charge

Additional Benefits	
Prescription Drug Benefit	Prescription Drug Benefits are payable as follows: Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Injury which occurs during the Policy Year are payable as follows: 100% after a $15 Co-pay for each generic prescription drug, and a $35 Co-pay for each brand name prescription drug , and a $50 co-pay for each specialty prescription drug. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement. Please use your Caremark ID card when obtaining your prescriptions. Prior Authorization is required for certain Prescription Drugs, Imitrex, certain stimulants, growth hormones and for any Prescription quantities larger than a 30-day supply. (This is only a partial list). Medications not covered by this benefit include, but are not limited to: allergy sera, inhalers, all acne medications, contraceptive devices, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. (This is only a partial list).
Diagnostic Testing for Learning Disabilities	Preferred Care: After a $25 Co-pay per visit, 80% of the Negotiated Charge Non-Preferred Care: After a $25 Co-pay per visit, 80% of the Usual and Customary Charge

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 90 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.

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; 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; hair growth or removal; learning disabilities except for prescription drugs prescribed by a physician to treat such disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind), with the exception of screening, counseling or behavioral interventions for the treatment of obesity and 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.

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 for whom an application has been received and 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 one 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 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 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 $7,500, 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 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.

CLEFT LIP AND CLEFT PALATE For children under the age of 18, coverage will be provided for the cost of treating cleft lip and cleft palate. The coverage shall include benefits for medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventative and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology and nutrition services, if such services are prescribed by the treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to the treatment of the cleft lip, cleft palate or both.

Benefits are subject to copayment, deductible, and coinsurance provisions, and other general exclusions or limitations included in the policy to the same extent as other health care services covered by the policy.

Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this provision.

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 Upon proof a Covered Person incurred 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, we will pay a benefit for the Usual and Customary charges not to exceed the Maximum Benefit on the Schedule.

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 glycosyloated hemoglobin, or HbAlc, 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 malabsorbtion 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.

HEARING AIDS Coverage will be provided for any child, 21 years of age or younger, who is insured under the policy, for the full cost of one hearing aid per hearing impaired ear up to [$2000] for each hearing aid every 36 months upon a written statement from the child's treating physician that the hearing aids are necessary regardless of etiology. Coverage shall include all related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments and supplies, including ear molds.

The insured may choose a higher priced hearing aid and may pay the difference in cost above the $2,000 limit without any financial or contractual penalty to the insured or to the provider of the hearing aid.

The benefits will not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefits provided under the Policy.

"**Audiologist**" means a person licensed as an audiologist in the commonwealth.

"**Hearing aid**" means a wearable aid or device, not including surgical implants, which is inserted directly into the ear or worn with an ear mold and air conduction receiver or bone oscillator attachment and any part, attachment or accessory but excluding batteries, cords and accessories thereto, designed for or offered for the purpose of aiding or compensating for hearing loss.

"**Hearing instrument specialist**" means a person licensed as a hearing instrument specialist in the commonwealth.

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 medial 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.

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 35 or younger or during a period of 6 months if the female is over the age of 35. If a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

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 mastecomy 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 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.

C. Benefits shall be provided on the same basis as any other Sickness for covered Dependent children under the age of 26 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 nondiscriminatory 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 noncustodial treatment for such mental disorders to take place in the least restrictive clinically appropriate setting. For purposes of this benefit, inpatient services may be provided 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.

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.

Intermediate Services means a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate Services include, but are not limited to, the following: Acute and other residential treatment; Clinically managed detoxification services; Partial Hospitalization; Intensive Outpatient Programs (IOP); Day treatment; Crisis Stabilization; In-home therapy services.

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 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 Pharmocopeia 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.

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 Usual and Customary charges not to exceed the Maximum Benefit on the Schedule. 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.

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 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 percent 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.

AUTISM SPECTRUM DISORDER: Coverage shall be provided on a nondiscriminatory basis to covered residents of the commonwealth and to all Covered Persons having a principal place of employment in the commonwealth for the diagnosis and treatment of Autism Spectrum Disorder in individuals.

1. "Treatment of Autism Spectrum Disorders" includes the following care prescribed, provided, or ordered for a Covered Person diagnosed with one of the Autism Spectrum Disorders by a licensed Physician or a licensed psychologist who determines the care to be Medically Necessary:
2. "Habilitative or Rehabilitative care" - professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.

3. "Pharmacy care" - medications prescribed by a licensed Physician and health-related services deemed Medically Necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the Policy for other medical conditions.
4. "Psychiatric care" - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
5. "Psychological care" - direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
6. "Therapeutic care" - services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

Benefits for the diagnosis and treatment of Autism Spectrum Disorder may be subject to annual or lifetime dollar limitation but such limitations will not be less than those imposed for other comparable Sickness under this Policy.

Benefits that are otherwise available to an individual under a health insurance policy will not be limited by us.

Coverage under this section shall not be subject to a limit on the number of visits a Covered Person may make to an autism services provider.

This section shall not affect an obligation to provide services to an individual under an individualized family service plan, an individualized education program or an individualized service plan. Services related to Autism Spectrum Disorder provided by school personnel under an individualized education program are not subject to reimbursement under this section.
All of the above benefits shall be subject to all Deductibles, coinsurance, copayments, limitations and any other Policy provisions.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan satisfies Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

LIMITATION 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 for Covered Persons under age 19 or 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. 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, participating in riot, civil disorder, civil commotion or acts of terrorism;
8. Committing or attempting to commit 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.
10. Expenses incurred as a result of dental treatment except as specifically provided for Covered Persons under age 19 and for treatment resulting from Injury to natural teeth;
11. Alcohol intoxication as defined in the state where the accident occurred;
12. Services that are provided normally without charge by the School's health center, infirmary or Hospital; or by any person employed by the School;
13. 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);
14. Elective Surgery or Elective Treatment;
15. Injury expenses resulting from the playing, practice, participating, or conditioning in any intercollegiate, club or intramural 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;
16. Expenses resulting from a motor vehicle accident for which benefits are payable from Other Valid Insurance;

17 Services and supplies not Medically Necessary for the diagnosis recommended by the attending physician;
18. Expenses incurred within the Covered Person's home country or country of regular domicile other than the United States;
19. Treatment of temporomandibular joint dysfunction (TMJ) and associated myofacial pain;
20. Expenses for allergy injections, vials, and allergy serum;
21. Services or supplies which are experimental or investigative in nature: including the treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice and any such items requiring federal or other governmental agency approval not received at the time services were rendered;
22. Homemaking, companion or chronic (custodial) care services. Charges of a home health aide who is a member of your household. Charges of any care provided by relatives (by blood, marriage or adoption);
23. Blood or blood plasma that is replaced by or for the patient;
24. Orthopedic appliances or devices, including orthopedic shoes, for treatment of the foot or conditions relating to the foot (except under Mandated Benefits);
25. Expenses or supplies related to sex changes, sexual dysfunctions or inadequacies with the exception of penile prosthesis required for physiological impotence;
26. Expenses incurred for the treatment of and supplies for weight reduction, hair growth or removal, birth control, or smoking cessation;
27. Expenses incurred for manipulation and massage;
28. Surgical, medical or other services of a Physician, surgeon or other person who is not legally qualified or licensed according to relevant sections of MA General Laws, or other governing bodies;
29. Birth control, sterilization or reversal, surgical procedures, or devices;
30. Personal and convenience items and completion of forms;
31. Alopecia Biofeedback-type services, Gynecomastia, Hirsutism, Nicotine Addiction, Patient Controlled Analgesia (PCA); and
32. Psychoanalysis or psychotherapy services you receive which are credited towards a degree or to further your education or training, regardless of symptoms that you may have.

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-existing Conditions for up to a 6 month period 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 Covered Person had Qualifying Previous Coverage. If the Covered Person had Qualifying Previous Coverage the Pre-existing Condition limitation will be reduced by the number of months covered under the Qualifying Previous Coverage.

The Pre-existing Condition Limitation does not apply to insured or dependents under age 19.

Pre-existing Conditions are defined as any 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 the Policy or a pregnancy existing on the Effective Date of Coverage.

RIGHT OF SUBROGATION

We will be fully and completely subrogated to the rights of a Covered Person against parties who may be liable to provide indemnity or make a contribution with respect to any matter that is the subject of a claim under the Policy.

The Covered Person further agrees to cooperate fully with us in seeking such indemnity or contribution including, where appropriate, when we are instituting proceedings at its own expense against such parties in the name of the Covered Person. The Covered Person further agrees that the Company will have a lien to the extent of benefits provided. Such lien may be filed with the person whose act caused the injury, the person's agent or a court having jurisdiction in the matter.

UTILIZATION REVIEW PROGRAM

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: BollingerColleges.com/BostonBaptist

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 Quality Improvement and Utilization Review programs, including full procedures for filing an inquiry, grievance or appeal can be obtained at: BollingerColleges.com/BostonBaptist. A paper copy of this information is available upon request from Bollinger, Inc.

COORDINATION OF BENEFITS ("COB") PROVISION

EXPLANATION When a person is covered by more than one Plan, the benefits that are paid will be shared between the Plans. This is done so that the total benefits paid will not be more than 100 percent of the Allowable Expenses for any Covered Person.

DEFINITIONS for this Provision Only:

Allowable Expense means the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services the reasonable value of each service will be considered as both an allowable expense and a benefit paid. When a plan uses capitation as the method of paying its providers of services, the reasonable value of such services shall be utilized as the basis of determining payment.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice.

Claim means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: (1) services (including supplies); (2) payment for all or a portion of the expenses incurred; (3) a combination of (1) and (2); or (4) an indemnification.

Claim Determination Period means the period of time, which must not be less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB, to determine whether over-insurance exists and how much each plan will pay or provide. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

As each Claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

Group-type Contract is a contract for coverage which is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.
Hospital Indemnity Benefits are provided during hospital confinement on other than an expense incurred basis.

Plan is a form of coverage with which coordination is allowed. Plan includes (a) group insurance and group subscriber contracts; (b) uninsured arrangements of group coverage; (c) group coverage through HMOs and other pre-payment, group practice and individual practice plans; (d) group-type contracts; (e) the amount by which hospital indemnity benefits exceed $100 per day; and (f) the medical benefits coverage in automobile policies to the extent permitted by law.

Plan does not include (a) non-group coverage except for coverage, except (1) group-type-contracts; (2) the amount by which hospital indemnity benefits exceed $100 per day; and (3) the medical benefits coverage in automobile policies to the extent permitted by law; (b) Medicare or other governmental benefits except to the extent permitted by law; (c) student accident coverages, Qualifying Student Health Insurance Programs ("QSHIPs") or other student health plans when designated as "excess only" or "always secondary plan", and (d) a plan under Medicaid, or any other plan when, by law its benefits are secondary to or in excess of those of any private insurance plan or other non-governmental plan.

Primary Plan is a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either: (a) the plan either has no order of benefit determination rules, or it has rules which differ from those permitted below. There may be more than one primary plan; or (b) all plans which cover the person use the order of benefit determination rules below, and under those rules the plan determines its benefits first.
Secondary Plan is a plan, which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules below decides the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which under the order of benefit determination rules below, has its benefits determined before those of that secondary plan.

RULES FOR COORDINATION OF BENEFITS

The Primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.
A plan may take the benefits of another into account only when, under these rules, it is secondary to that plan.

ORDER OF BENEFIT DETERMINATION

(1) The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which coverage the person as a dependent.
(2) If two or more plans cover a dependent child whose parents are not separated or divorced, the order of payment is:
   a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
   b) If both parents have the same birthday, the benefits of the plan, which covered the parent longer, are determined before those of the plan which covered the parent for a shorter period of time.
   c) The word "birthday" refers to month and day in a calendar year, not the year in which the person was born.
   d) If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits the birthday rule will determine the order of benefits.
(3) If two or more plans cover a dependent child whose parents are divorced or separated, the order of payment is:
   a) the plan of the parent with custody of the child;
   b) the plan of the spouse of the parent with custody of the child; and
   c) the plan of the parent not having custody of the child;
   d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of the terms, the benefits of that plan are determined first. Item (3) b) above does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has the actual knowledge.
   e) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in item (2) above.
(4) The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan, which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
(5) If none of the above rules determines the order of benefits, the benefits of the plan, which covered a person longer are determined before those of the plan which covered a person for a shorter term.
   a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24-hours after the first ended.
   b) The start of a new plan does not include:
      i) a change in the amount or scope of a plan's benefits;
      ii) a change in the entity which pays, provides or administers the plan's benefits;
      iii) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
   c) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group will be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN

A secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowance expenses. The amount by which the secondary plan's benefit have been reduced shall be used by the secondary plan to pay allowable expense, not otherwise paid, which were incurred during the claim determination period by the person for whom the claims are made. As each claim is submitted, the secondary plan determines its obligation to pay for allowance expenses based on all claims which were submitted up to that point in time during the claim determination period.

The benefits of the secondary plan will be reduced when the sum of benefits that would be payable for allowable expenses under the secondary plan in the absence of this section and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of the secondary plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.

MISCELLANEOUS PROVISIONS A secondary plan which provides benefits in the form of services may recover the reasonable value of the services from the primary plan, subject to the provisions governing allowable expense and claim determination period. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan, which provides benefits in the form of services.
A plan, which pays for or provides more benefits than it should under this COB provision may recover the excess from one or more of: (a) the person it has paid; (b) insurance companies; or (c) other organizations.

A plan with order of benefit determination rules which comply with 211 CMR 38.00 ("complying plan") may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in 211 CMR 38.00 ("non-complying plan") on the following basis:

a) if the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis;
b) if the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, such payment shall be the limit of the complying plan's liability; and
c) if the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the non-complying plan.

CLAIM PROCEDURE

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/BostonBaptist**

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 services provided for Emergency Medical Condition will be paid at the in-network level.

CLAIM PROVISIONS

NOTICE OF CLAIM We must be given written notice of claim within 30 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice must contain the Insured's name and enough information to identify him. Notice may be mailed to our Claims Administrator.

CLAIM FORMS When we receive notice of claim, the Insured will be sent forms to file proof of loss. If the forms are not sent within 15 days after we receive notice, then the Insured will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason if it is shown that written proof of the loss was given as soon as reasonably possible.

PAYMENT OF CLAIMS Claims for benefits provided by the Policy will be paid as soon as written proof is received and no later than 45 days of receipt of the completed forms for reimbursement. If we are unable to make payment for services provided within the time frame, we will notify the provider or Covered Person in writing of the reason(s) for nonpayment or of what additional information or documentation is necessary to complete the claim review. If we fail to comply with the terms of this provision, in addition to any benefits payable, interest on such benefits will accrue beginning forty-five (45) days after receipt of the claim at a rate of one and one-half (1 1/2) percent per month, not to exceed eighteen (18) percent per year. The interest payments shall not apply to a claim which we are investigating because of suspected fraud.

All benefits are paid directly to the provider or Covered Person, as directed by the Covered Person. If a benefit is unpaid at the Covered Person's death or if we feel the Covered Person is not able to give a valid receipt for payment, we may pay an amount up to $1,000 to any relative by blood or marriage who we deem to be equitably entitled. Any payment we make in good faith will fully discharge us to the extent of the payment.

PHYSICAL EXAMINATION AND AUTOPSY At our expense, we have the right to have the Insured examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS No legal action may be brought to recover against the Policy within 45 days after written proof of loss has been given. No such action will be brought after three years from the time written proof of loss is required to be given.

If a time limit of the Policy is less than allowed by the laws of the state where the Insured lives, the limit is extended to meet the minimum time allowed by such law.

STUDENT ASSISTANCE SERVICES
(Administered by On Call International)

The following services are available for use by the students insured under this plan. For additional information, please refer to the plan web site: www.BollingerColleges.com/ncwc

Nurse Helpline Clinical assessment, education and general health information performed by a registered Nurse counselor to assist in identifying the appropriate level and source(s) of care for Students. Nurses shall not diagnose a Student's ailments.

Travel Assistance Services: 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.

PRESCRIPTION DRUG BENEFIT

Prescriptions filled at a Caremark Pharmacy: after a $15 co-pay for each generic prescription drug, $35 co-pay for each brand name prescription drug, and a $50 co-pay for each specialty prescription drug. 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. If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms or for information about mail-order prescriptions or network pharmacies, please call Caremark Customer Care toll free at 1-800-391-6443. Note: Caremark is not connected with Monumental Life Insurance Company. 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.

GRIEVANCE PROCEDURE

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: BollingerColleges.com/BostonBaptist.

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.

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

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/BostonBaptist

SERVICING AGENT

Collegiate Risk Management
800-922-3420
www.Collegiaterisk.com

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.

POLICY FORM: MLSH5100GBP.MA 26210981