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

Student Injury and Sickness Insurance Evidence of Coverage Brochure 2013-2014

Designed for the Students of

Le Cordon Bleu
College of Culinary Arts
A Private, Two-Year College
Boston Campus

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.

Underwritten By:
Monumental Life Insurance Company
Cedar Rapids, Iowa
a Transamerica Company
(the "Company")

Visit us on the Web: www.BollingerColleges.com/LCB

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.

Policy Number: CMA813J

TO STUDENTS AND PARENTS

The College has, pursuant to Massachusetts Law, implemented a Student Injury and Sickness Insurance Plan. The Plan is designed to provide protection against unexpected and frequently heavy expenses for accident or illness.

Massachusetts Law mandates that all full-time students have Health Insurance coverage. To ensure compliance with the law, all full-time (9 plus credit) students are automatically enrolled in the Student Injury and Sickness insurance plan.

The plan has been designed to comply with Massachusetts Law in a manner most economical to the student body. As a result, there are certain limitations that should be carefully noted. 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 should retain this brochure for reference purposes.

ELIGIBILITY

Massachusetts state law requires all full-time and qualifying part-time students to enroll in a Student Accident and Sickness plan unless satisfactory evidence is provided to the school that the student is enrolled in comparable coverage for the full academic year. A part-time student is one who is participating in at least 9 credits of the academic requirements for full-time students. The deadline to waive coverage is within 7 days of the first day of their beginning term.

Eligible students who do enroll may also insure their dependents. Eligible dependents are the spouse, natural, foster and adopted children under the age of 26. Dependent eligibility expires concurrently with that of the Covered Person student.

EFFECTIVE AND TERMINATION DATES

The Master Policy on file at the school becomes effective at 12:01 a.m., April 7, 2013. Coverage becomes effective on that date. The Master Policy terminates at 12:00 a.m. on April 7, 2014. Coverage terminates on that date or at the end of the period through which the rate is paid, whichever is earlier.

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

PREMIUM REFUND

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased will not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid, and no refund will be allowed.

A covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, and any covered dependents, upon written request received by Bollinger, Inc. within 90 days of withdrawal from school.

EXTENSION OF BENEFITS AFTER TERMINATION

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

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

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

COVERAGE RATES

	9 Month Rate	15 Month Rate	21 Month Rate
Student-Under Age 26	$ 902	$1,504	$2,105
Student-Age 26 or Older	$1,543	$2,571	$3,600
Each Dependent	$1,168	$ 1,947	$2,726

*Rates include an administrative fee.

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 this Policy is in force.

COVERED PERSON means an eligible student and/or a Dependent 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.

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; breast reduction; 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 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:
It must be operated according to law; 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; It must provide diagnostic and surgical facilities supervised by Physicians; Registered Nurses must be on 24-hour call or duty; The care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged 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. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

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 the 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.

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

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 Covered Person 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 causes a 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.

BASIC PLAN COVERAGE

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/ You may also request a copy from Bollinger by contacting them at 1-866-267-0092.

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 $500,000. 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 70% In Network or 50% Out of Network of the semi-private or intensive care unit rate.

Miscellaneous Hospital Expense: We will pay 70% In Network or 50% Out of Network 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 tests, 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 70% In Network or 50% Out of Network of the Expense. 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 70% In Network or 50% Out of Network of the amount payable for the operation. If the surgery requires the services of an Assistant Surgeon, we will pay up to 70% In Network or 50% Out of Network 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 70% In Network or 50% Out of Network of the Expense for such services.

Ambulance Expense: When you require the use of an ambulance, we will pay 70% In Network or 70% Out of Network of the Expense.

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 70% In Network or 50% Out of Network of the Expense, subject to the following co-pays:

- Hospital emergency room visit does not result in an admission, the co-pay will be $250.

- Hospital emergency room visit that does not result in an admission, when doctor ordered, the co-pay will be $150.
- Hospital outpatient department visit co-pay will be $150.
- Doctor visit co-pay will be $15.

Copay will 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 treatments. For any additional 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 70% In Network or 50% Out of Network of the Expense.

Consultant or Specialist Expense: When you require the services of a consultant or specialist to confirm or determine a diagnosis, we will pay 70% In Network or 50% Out of Network the Expense.

Prescribed Medicine Expense: When you require prescription medications ordered by the attending Doctor, your co-pay will be $15 for Generic drugs, $35 for Brand drugs or $50 for Specialty drugs.

Maternity Expense: Expenses for pregnancy including complications are covered to the same extent coverage is provided for any other Sickness.

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 prevent pregnancy that have been approved by the United States Food & Drug Administration.

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-existing Conditions for up to six month period 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 two continuous years; 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.

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 in to 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 an accredited or licensed 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) an accredited or licensed 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 furnished by a facility in this clause 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.

AUTISIM SPECTRUM DISORDER BENEFIT

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.

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 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. Such Medically Necessary services shall be provided by early intervention specialists who are working in early intervention programs certified 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, appropriate 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 sever 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 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.

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 hormone replacement therapy services 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 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 an 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 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 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 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.

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 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 extent tot he 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.

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 Massachusetts statutory requirement that you have health insurance meeting these standards.

PREFERRED PROVIDER ORGANIZATION

The Plan Administrator contracts with a Preferred Provider Organization ("PPO"), First Health Network ("First Health"), 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.myfirsthealth.com or
call toll free 1-800-526-1379.
A directory of preferred providers is available on the website.

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.

COORDINATION OF BENEFITS

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.

In a Policy Year this Policy will pay:

(1) its regular benefits in full; or

(2) a reduced amount of benefits if a Covered Person is covered under more than one Plan. If a reduced amount of benefits is paid using this provision, each benefit that would be payable in the absence of this provision:

a) will be reduced to the same proportion; and

b) the reduced amount will be charged against any benefit limit of this Policy that applies.

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 up to $7,500 for the preparation and transportation of the deceased's body for burial or cremation in his home country or country of regular domicile subject to the approval of the Plan Administrator of the Policy. If applicable, such action will be in accordance with any international standards. The benefit payable is not to exceed the maximum benefit shown on the schedule, and death must occur at least 100 miles away from the Covered Person's city of residence. Benefits provided by this provision are paid in addition to any other benefits payable under the Policy.

LIMITATIONS AND 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 treatment resulting from Injury to natural teeth;
2. Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations 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 accident. 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 a 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. Expenses resulting from a motor vehicle accident for which benefits are payable from other valid insurance;
11. Accident sustained or Sickness contracted as a result of the use of alcohol or the misuse of drugs, medicines, narcotics or halluciogens, unless taken in the dosage and or the purpose prescribed by the Covered Person's Physician;
12. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
13. Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate or intramural sport, contest or competition sponsored by the University, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant;
14. Routine screenings or tests which are not Medically Necessary for the diagnosis or treatment of your condition or which are not specifically ordered by the admitting Physician (except as stated in the Mandated Benefits section of this Policy);
15. Elective Surgery or Elective Treatment.

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. Obtain a claim form from the Plan Website: **www.BollingerColleges.com/LCB**
3. 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.
4. We recommend that within 60 days the student follow up with his health care provider(s) to be sure that claims have been paid. If covered charges remain unpaid, the student should confirm with Bollinger, Inc. that the information necessary to pay the claim has been received. If you need additional help, you may contact Collegiate Risk Management, at 800-922-3420.
5. Questions should be referred to Bollinger, Inc. at 1-866-267-0092.
6. All claims should be sent to:

BOLLINGER, INC.
P.O. BOX 727
SHORT HILLS, NJ 07078-0727

CLAIM INQUIRY AND APPEAL PROCESS

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, Insurance Services.

- 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, 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/LCB.

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, Insurance Services 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 Quality Improvement and Utilization Review programs, including full procedures for filing procedures for filing an inquiry, grievance or appeal can be obtained at: www.BollingerColleges.com/LCB. A paper copy of this information is available upon request from Bollinger Insurance at 1-866-267-0092.

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 an Emergency Medical Condition will be paid at the in-network level.

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

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

Underwritten By:
Monumental Life Insurance Company
Cedar Rapids, Iowa

CLAIMS OFFICE
For questions regarding claim or claims status:

Bollinger
Insurance Solutions

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

SERVICING AGENT
Collegiate Risk Management
1-800-922-3420
www.collegiaterisk.com

Preferred Provider 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
Brochure Form: MLSH5100GBC.MA

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