

2006 – 2007

Especially designed for the students of

Berklee
COLLEGE OF MUSIC



Student Accident and Sickness Insurance Plan

Boston, Massachusetts

Policy Number CUH201175

**BERKLEE COLLEGE OF MUSIC
STUDENT ACCIDENT AND SICKNESS
INSURANCE PLAN**

September 1, 2006 - August 31, 2007

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THE STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This brochure describes the insurance coverage under the Berklee College of Music Student Accident and Sickness Insurance Plan available to Insured Students and Dependents.

This Plan is underwritten by Combined Insurance Company of America. The exact provisions governing this Student Accident and Sickness Insurance Plan are contained in the Master Policy which will be issued to the College.

STUDENT ELIGIBILITY

Massachusetts Law requires all College Students registered for at least 75% of full-time credits to carry health insurance. At Berklee College of Music, all students enrolled at the College are eligible to enroll in the Student Accident and Sickness Insurance Plan.

ELIGIBILITY AND ENROLLMENT

All registered students at Berklee College of Music taking credit hours are eligible to enroll in this insurance Plan at check-in and the premium is added to their tuition billing unless proof of comparable coverage is furnished. Eligible dependents of students enrolled in the Plan may participate in the plan on a voluntary basis.

In the event you waive the Student Accident and Sickness Insurance Plan coverage and then lose your current coverage due to a qualifying event, (i.e. your parent loses coverage or you reach the maximum age limit available under a parent's plan), you have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage. For petitions received after the 31 days, the effective date of coverage will be the date that the petition is received at Koster Insurance Agency. If approved, the premium will not be prorated.

Berklee College of Music reserves the right to reject a waiver request when the insurance carrier or claims administrator is not a domestic or U.S. based company. **International students may not waive the Student Accident and Sickness Plan unless they are covered by an insurance company based in the United States.**

WAIVER PROCESS

Students who do not want to enroll must complete either the Online Waiver Form, at my.Berklee.net by August 26, 2006 for Annual enrollment, January 6, 2007

for newly enrolled or returning students for Spring Semester, and May 13, 2006 for newly enrolled or returning students for Summer Semester. Students are encouraged to use the Online Waiver Form to waive the student insurance plan to expedite the processing of the waiver.

STUDENT ACCIDENT ONLY INSURANCE PLAN

Enrollment in the Accident Only Insurance Plan is required for all students not enrolled in the Student Accident and Sickness Insurance Plan. When Injury requires treatment, payment will be made for Covered Medical Expenses resulting from an Injury occurring during the term insured. Covered Medical Expenses are those Reasonable and Customary charges for physicians and surgeons, hospital confinement, x-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other Reasonable and Customary Covered Medical Expenses incurred during the term insured. The Maximum Benefit is \$5,000 for each injury.

DEPENDENT ELIGIBILITY AND ENROLLMENT

Students enrolled in the Student Accident and Sickness Insurance Plan may also enroll their dependent(s) as defined with an additional cost. "Dependent" means: (a) the Insured Student's spouse; or (b) the Insured Student's unmarried children under the age of twenty years; or (c) unmarried children of the Insured Student's Dependent child, provided the children are under the age of twenty years. The term "children" includes an Insured Student's biological children; step-children; and adopted children from the date of placement in the Insured Student's home and who depend on the Insured Student for their full support. Coverage for such newborn children will consist of coverage for sickness or accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child, for dependent benefits from and after the moment of birth, or any child placed with the Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption. To continue the child's dependent benefits past the first 31 days, or to obtain any other dependent

coverage, the Insured Student must complete and submit either the Dependent Enrollment Form with payment directly to Koster Insurance Agency or an online Dependent Enrollment Form within 31 days of the child's birth or date of placement for adoption or date of marriage. Contact Koster Insurance Agency to obtain a Dependent Enrollment Form.

The term "children" includes an Insured Student's biological children; step-children; and adopted children from the date of placement in the Insured Student's home. It also includes an Insured Student's newborn dependent children who, as of the last day of the 30-day period beginning with the date of birth, are covered under Creditable Coverage; or an Insured Student's adopted dependent children under the age of 18, who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, are covered under Creditable Coverage (except this shall not apply to coverage the adopted child may have had before such adoption or placement.)

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of physical handicap or mental retardation; (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance. Within 31 days after the child reaches the age limit, the Insured Student must send Us proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age. Any dependent on active duty in any military, naval or air force of any country is not eligible for coverage under this Policy.

Dependents who are regular employees of Berklee College of Music are not eligible. A Dependent cannot be insured under this Plan if the Insured Student loses eligibility under the Student Accident and Sickness Insurance Plan.

Previously Insured Students and their Dependents must be re-enrolled by submitting a new Dependent Enrollment Form by October 1, 2006 in order to avoid a break in coverage. If this deadline is not met, the effective date of coverage will be the postmark date on the envelope. An Insured Person who has a break in continuous coverage will not be covered for any Pre-existing Condition that originated before or during such break subject to policy terms and conditions.

ALTERNATIVE COVERAGE

If you do not meet the eligibility requirements of this plan, please call Koster Insurance Agency at 1-800-457-5599 for information on alternative insurance plans that may be available.

PLAN COSTS AND PERIOD OF COVERAGE

	Annual 9/01/06 - 8/31/07	Spring 1/15/07 - 8/31/07	Summer 5/15/07 - 8/31/07
Student*	\$1,448.00	\$ 988.00	\$474.00
Spouse	\$3,167.00	\$2,046.00	\$976.00
Child(ren)	\$2,261.00	\$1,451.00	\$694.00

***This fee reflects the accident only fee charged to all students**

POLICY TERM

The insurance under Berklee College of Music Student Accident and Sickness Insurance Plan for the Annual Policy is effective at 12:01 a.m. on September 1, 2006. An eligible student's coverage becomes effective on that date or the date the application and full premium are received by the College or Koster Insurance Agency, whichever is later. The Annual Policy terminates on August 31, 2007 or at the end of the period through which the premiums are paid, whichever is earlier.

The insurance for the Spring Semester is effective at 12:01 a.m. on January 15, 2007 or the date the application and full premium are received by the College or Koster Insurance Agency, whichever is later and terminates on August 31, 2007.

The insurance for the Summer Semester is effective at 12:01 a.m. on May 15, 2007 or the date the application and full premium are received by the College or Koster Insurance Agency, whichever is later, and terminates on August 31, 2007.

PREMIUM REFUND POLICY

If an Insured Student withdraws from the College after the start of the semester, his or her coverage will remain in effect until the end of the term for which he or she was charged premium. Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request of the withdrawal from school, and coverage will end as of the date of such entry.

EYEMED VISION CARE

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network consists of over 20,000 independent providers and retail stores nationwide, including LensCrafters, Target and Pearle Vision. This is not an insurance plan; there is no waiting period. You can take advantage of the savings through EyeMed immediately upon receipt of Your separate EyeMed vision plan ID card. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% and 45% off regular retail pricing. In addition, You can receive discounts from 5% to 15% off laser correction surgery at some of the nation's most highly qualified laser correction surgeons. To locate a participating provider, You can call 1-866-8EYEMED or go online at www.enrollwitheyemed.com. This plan is not underwritten by Combined Insurance Company of America.

DENTAL SAVINGS PROGRAM

The Dental Savings Program is an exclusive plan for students enrolled in the Student Accident and Sickness Insurance Plan. The program is operated by Basix, LLC to provide students access to general and specialty dental care from a select network of local dentists. The network of providers have met strict credentialing and quality assurance requirements. The network of participating dental providers have agreed to accept negotiated prices for the services they provide. Students will be responsible for paying for services they receive at the time of the visit. Students will generally save from 20% to 50% of charges for a wide range of dental services – from routine cleanings to root canals. Because the Dental Savings Program is not insurance, there are no claim forms, annual maximums, benefit limitations and conditions or other plan provisions. Students can log onto the website, www.basixstudent.com to locate participating dental providers, download the fee schedule and learn more about the Program. This plan is not underwritten by Combined Insurance Company of America.

NETWORK PROVIDERS

The Berklee College of Music Student Accident and Sickness Insurance Plan provides access to hospitals and health care providers locally and throughout the country through the CCN Preferred Provider Network. The advantage to using a Network Provider is that Network Providers have agreed to accept a

predetermined fee or Preferred Allowance as payment for their services. Consequently, when Insured Students use Network Providers, Out-of-Pocket expenses will be less because any applicable copayments will be based on a Preferred Allowance. The Insured Person should be aware that Network Hospitals may be staffed with Non-Network Providers. Receiving services or care from a Non-Network Provider at a Network Hospital does not guarantee that all charges will be paid at the Network Provider level of benefits.

It is important that the Insured Person verify that his or her Doctors are Network Providers when calling for an appointment or at the time of service. The most efficient and accurate way to identify Network Providers is to contact CCN by calling 1-888-685-7774 or www.ccnusa.com.

For students who are new to the Boston area or who do not have an existing relationship with a doctor, Harvard Vanguard, conveniently located at 133 Brookline Avenue in Kenmore Square, is a Preferred Provider in the CCN network. Harvard Vanguard is a multi-specialty group practice offering more than 35 medical and surgical specialties. Their regular hours are from Monday through Friday, 7:30 a.m. to 9:00 p.m.

Harvard Vanguard also offers Urgent Care hours for sudden illnesses “after hours” and during evenings and weekends. Urgent Care hours are Monday through Friday, 5:00 p.m. – 8:00 p.m., Saturday 10 a.m. – 5:00 p.m. and Sundays and Holidays from 12:00 p.m. – 5:00 p.m. You can reach Harvard Vanguard at 617-421-1000 or visit www.harvardvanguard.com.

DEFINITIONS

Coinsurance means the percentage of the Expenses for which the Insured Person is responsible for a covered service.

Copayment means the specified dollar amount an Insured Person must pay for specified charges. The Copayment is separate from and not a part of the deductible or Coinsurance.

Covered Charges or Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of Reasonable and Customary Expense; (c) not in excess of the charges that would have been made in the absence of this Insurance; and (d) incurred while this Plan is in force as to the Insured Person except with respect to any expenses payable under the Extension of Benefits Provision.

Deductible means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state or residence of such practitioners; or (c) a podiatrist or optometrist performing covered services a podiatrist or optometrist rendered within the scope of his or her license; or (d) a nurse midwife when such services are within the lawful scope of practice for a certified nurse midwife; or (e) a certified registered nurse anesthetist or nurse practitioner designated as such by the board of registration in nursing, if: (i) the service rendered is within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice by the board of registration in nursing; and (ii) the policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth; or (f) a chiropractor when performing covered services rendered within the scope of his or her license; or (g) a dentist when performing covered services rendered within the scope of his or her license.

Elective Treatment means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage. Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examinations.

Experimental or Investigational Care means a service or supply: (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or (b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished. We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

Grievance means any oral or written complaint submitted to Us or Our authorized TPA that has been initiated by an Insured Person, or an Insured Person's authorized representative, concerning any aspect or action of Combined relative to the Insured Person, including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of 105 CMR 128.000 et seq.

Injury means bodily injury caused by an accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student and their covered Dependent(s) while insured under this Plan.

Loss means medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan.

Medical Emergency 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 an Insured Person or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in 1867(e)(1)(B) of the Social Security Act.

Medically Necessary means that a service, drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, Drug or supply is provided, as determined by whether: (a) it is the most appropriate available supply or level of service for the Insured Person in question considering potential benefits and harms to the individual; or (b) it 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.

Network Providers are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

Non-Network Providers have not agreed to any pre-arranged fee schedules.

Per Condition Aggregate Maximum means for each Insured Person, the total amount of benefits payable for each Injury or Sickness under the Student Health

Insurance Policy or Policies issued to this Policyholder before this Policy.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Covered Services.

Reasonable and Customary Expense means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

Sickness means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and complications of pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us or Our means Combined Insurance Company of America.

You, Your or Yours means the Insured Student.

EXCLUSIONS AND LIMITATIONS

Pre-existing Conditions

Pre-existing Condition is a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended or received by a Doctor during the six (6) consecutive months prior to the Effective Date of the Insured Person's coverage under this policy.

The Pre-existing Condition Waiting Period is six (6) months. Except for a Medical Emergency, coverage will not be provided for a Pre-existing Condition until the waiting period has elapsed. The Pre-existing Condition Waiting Period applies to all persons covered under this Policy and begins on the Insured Person's Effective Date.

If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a six (6) consecutive month period has passed from the Insured Student's effective date; and (b) We will pay only Loss or Expense incurred after such six (6) consecutive month period.

A period of Creditable Coverage will be credited if the previous Creditable coverage was continuous to a date not more than 30 days prior to the Effective Date of the new coverage.

Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage, the Pre-existing Condition Waiting Period will have to be satisfied again.

Creditable Coverage

This term means the following medical, hospital, and surgical coverage an Insured Person had prior to the Effective Date under this Policy.

(a) an employee group health plan; (b) health plan including but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to a natural person who is enrolled in a qualifying student health insurance program in this state or of another state; (c) Medicare; (d) Medicaid; (e) Chapter 55 of title 10, United States Code. (CHAMPUS); (f) a medical care program of the Indian Health Services or of a tribal organization; (g) a State health benefits risk pool; (h) a health plan offered under the Federal Employee Health Benefits Program; (i) a public health plan as defined under Federal regulations; (j) a health benefit plan under Section 5(e) of the Peace Corps Act; (k) any other similar coverage permitted under State/Federal law or regulations; (l) any other Creditable Coverage as defined by subsection (c) of section 2701 of Title XXVII of the Federal Public Health Services Act; or (m) any other publicly sponsored program, provided in this State or elsewhere, or medical, hospital and surgical care.

Exceptions to Pre-Existing Conditions

The Pre-existing Condition exclusion does not apply to any of the following: (a) pregnancy, including complications, if such condition is covered under this Policy; (b) a covered newborn dependent child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; (c) a covered adopted dependent child under the age of 18, who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage (except this shall not apply to coverage the adopted child may have had before such adoption or placement); or (d) covered charges for the treatment of infertility.

Prior Plan means (a) the Student Health Insurance policy or policies issued to the Policyholder immediately before the current Policy; and (b) other policies providing Qualifying Previous Health Coverage as defined in this Policy. Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will not apply even though the Prior Plan provided that it

will not duplicate the benefits under another Policy. Also, the total amount of benefits payable for Injury or Sickness under this Policy and the Prior Plan cannot exceed the Per Condition Aggregate Maximum. Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.

SCHEDULE OF BENEFITS

The Policy provides benefits for covered charges incurred by an Insured Person for loss due to a covered Accident or Sickness up to a Maximum Benefit of \$35,000, after the Non-Network Deductible of \$100.00 has been satisfied. Any Covered Charges received from a Network Provider will be paid at the Network Provider level of benefits. If the Covered Charges are incurred due to an emergency treatment, benefits will be paid at the Network Provider Level of Benefits. In all other situations, reduced, or lower benefits will be provided when an Non-Network provider is used. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Charges include:

BENEFITS		NETWORK PROVIDER	NON-NETWORK PROVIDER
Per Condition Maximum Benefit Per Policy Year			\$35,000
Deductible		Not Applicable	\$100.00 Per Insured Person for each Accident and Sickness
HOSPITAL EXPENSE BENEFITS			
Hospital Room and Board Expense , Services include semi-private room, nursing services, special care unit		100% of Preferred Allowance	80% of Reasonable and Customary Expense
Hospital Miscellaneous Expense , Services include anesthesia, operating room, diagnostic x-ray, laboratory tests, prescribed drugs & medicines, dressings, supplies, physical & occupational therapy, other necessary prescribed hospital expenses		100% of Preferred Allowance	80% of Reasonable and Customary Expense
In Hospital Doctor's Fees and Medical Expense , Services include visits by a doctor who may or may not have performed surgery		100% of Preferred Allowance	80% of Reasonable and Customary Expense
Pre-Admission Testing		Covered under Hospital Expense	
Registered Nurses's Services , private duty nurses care		100% of Preferred Allowance	80% of Reasonable and Customary Expense
SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)			
Surgical Expense Benefit		100% of Preferred Allowance	80% of Reasonable and Customary Expense, up to a maximum of \$5,000 per Accident or Sickness

BENEFITS	NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
SURGICAL EXPENSE BENEFITS (Continued)		
Multiple Surgical Procedures	Paid according to Policy Language. See page 18 for complete description.	
Assistant Surgeon Expense Anesthetist Expense	100% of Preferred Allowance included under Surgical Expense Benefit	80% of Reasonable and Customary Expense, included under Surgical Expense Benefit up to maximum of \$5,000 per Accident or Sickness
Second Surgical Opinion Consultation Expense, Covered Charges include any required x-rays and diagnostic tests	100% of Preferred Allowance up to \$125.00 Per Accident or Sickness	80% of Reasonable and Customary Expense up to \$125.00 Per Accident or Sickness
OUTPATIENT BENEFITS		
Outpatient Miscellaneous Expense , Services include diagnostic x-ray and laboratory, physical therapy (limited to one visit per day), injections (including routine immunizations when administered in the Physician's office and charged on the Physician's statement), radiation therapy, chemotherapy, hospital emergency room, hospital outpatient department, doctor services, chiropractic services and consultant services.	100% of Preferred Allowance up to a maximum of \$2,000 per Accident or Sickness Office Visit \$15.00 Outpatient Hospital Visit \$15.00 Emergency Room Visit \$100.00 (Reduced to \$50.00 if admitted)	80% of Reasonable and Customary Expense up to a maximum of \$2,000 per Accident or Sickness Office Visit \$15.00 Outpatient Hospital Visit \$15.00 Emergency Room Visit \$100.00 (Reduced to \$50.00 if admitted)
High Cost Procedure Expense , For Outpatient Procedures in excess of \$200.00, Services include, but are not limited to CAT scan, MRI, Ultrasound and Laser Treatment	100% of Preferred Allowance up to a maximum of \$2,000 per Accident or Sickness	80% of Reasonable and Customary Expense up to a maximum of \$2,000 per Accident or Sickness
Ambulance Expense	80% of Reasonable and Customary Expense up to \$250.00 per Policy year	
Voluntary Termination of Pregnancy Expense	100% of Preferred Allowance up to a maximum of \$350.00	

BENEFITS		
	NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
MENTAL ILLNESS EXPENSE (Refer to page 29 for details)		
Inpatient Mental Illness Expense Benefit for Non-Biologically Based Conditions	100% of Preferred Allowance up to 60 days per policy year	80% of Reasonable and Customary Expense up to 60 days per policy year
Inpatient Mental Illness Health Expense Benefit for Biologically Based Conditions	Paid as any other Sickness	Paid as any other Sickness
Outpatient Mental Illness Expense for Non-Biologically Based Conditions	\$15.00 per Office Visit, then 100% of Preferred Allowance up to 24 visits per policy year	\$15.00 per Office Visit, then 80% of Reasonable and Customary Expense up to 24 visits per policy year
Outpatient Mental Illness Expense for Biologically Based Conditions	\$15.00 per Office Visit, then 100% of Preferred Allowance up to \$2,000 per condition	\$15.00 per Office Visit, then 80% of Reasonable and Customary Expense up to \$2,000 per condition
ALCOHOL AND SUBSTANCE ABUSE EXPENSE (Refer to page 20 for details)		
Inpatient Alcohol and Substance Abuse Expense	100% of Preferred Allowance up to 30 days per policy year	80% of Reasonable and Customary Expense up to 30 days per policy year
Outpatient Alcohol and Substance Abuse Expense	100% of Preferred Allowance up to \$500 per policy year	80% of Reasonable and Customary Expense up to \$500 per policy year
ADDITIONAL BENEFITS		
Dental Accident Expense , injury to sound, natural teeth	80% of R&C Expense up to a maximum of \$1,000 per injury	
Dental Sickness Expense removal of impacted or unerupted wisdom teeth	100% of R&C Expense, up to a maximum of \$100.00 per tooth	
Prescription Drug Expense , including prescription contraceptive drugs and devices	\$10.00 for a 30-day supply of a generic drug or \$25.00 for a 30-day supply of a brand name drug up to \$1,000 per policy year. Prescriptions must be filled at a Medco pharmacy	

BENEFITS		NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
ADDITIONAL BENEFITS (Continued)			
Hearing Examinations and Hearing Aids			Covered as any other Sickness
One Routine Annual Physical			Covered as any other Sickness
Braces and Appliances, a written prescription must accompany the claim			Covered under Outpatient Miscellaneous
Home Health Care			Covered as any other Sickness
Emergency Medical Evacuation and Repatriation of Remains			Covered up to the combined plan maximum
STATE MANDATED BENEFITS (Refer to page 25 for details)			
Bone Marrow Transplant for Treatment of Breast Cancer Expense			Covered as any other Sickness
Cardiac Rehabilitation Expense			Covered as any other Sickness
Cytological Screening Expense, including screening and examination			After a \$15.00 copayment, covered as any other Sickness
Early Intervention Services Expense			Covered at 80% of the actual Expense incurred up to a maximum of \$5,200 per policy year up to a maximum of \$15,600
Diabetic Diagnosis and Treatment			Covered as any other Sickness
Hearing Screening Test Expense			Covered as any other Sickness
Hospice Care Treatment Expense			Covered as any other Sickness
Human Leukocyte Antigen Testing Expense			Covered as any other Sickness
Infertility Expense			Covered as any other Sickness

BENEFITS		NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
STATE MANDATED BENEFITS (Continued)			
Maternity Expense		Covered as any other Sickness	
Mammography Examination Expense		Covered as any other Sickness	
Non-prescription Enteral Formulas Expense		Covered as any other Sickness up to \$2,500	
Preventive and Primary Expense - Children		80% of Actual Expenses incurred	
Scalp Hair Prosthesis Expense		Covered as any other Sickness up to \$350.00	
Services Performed by Certified Registered Nurse Anesthetist and Nurse Practitioners Expense		Covered as any other Sickness	
Special Medical Formulas Expense		Covered as any other Sickness	
Hormone Replacement Therapy and Contraceptive Services Expense		Covered as any other Sickness up to \$750.00	

DESCRIPTION OF MEDICAL INSURANCE BENEFITS

Payment will be made as allocated herein for covered medical expenses incurred for an Injury or Sickness while insured under this Plan, not to exceed the Per Condition Maximum of \$35,000 Per Policy Year. This Plan has an Out-Of-Network Deductible of \$100.00 for each Accident and Sickness.

HOSPITAL EXPENSE BENEFITS

- **Hospital Room and Board Expense**

When, by reason of Injury or Sickness, an Insured Person requires Hospital Confinement, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers of the Hospital room and board Covered Charge for a semi-private room containing two or more beds including meals, special diets and nursing services incurred for the period of such Hospital Confinement. Coverage includes a bed in a special care unit.

- **Miscellaneous Hospital Expense Benefit**

Miscellaneous Hospital Expense includes expenses incurred for: anesthesia, anesthesia supplies and services; operating, delivery and treatment rooms and equipment; diagnostic X-ray and laboratory tests; lab studies; oxygen tent; blood and blood services; prescribed drugs and medicines; medical and surgical dressings, supplies, casts and splints; radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; intravenous injections and solutions, and their administration; physical and occupational therapy; and other necessary and prescribed hospital expenses. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense for Non-Network providers incurred by the Insured Person during the period of Hospital Confinement.

- **In Hospital Doctor's Fees and Medical Expense**

When, by reason of Injury or Sickness an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers.

SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

- **Surgical Expense**

When by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient or outpatient basis, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers up to a maximum of \$5,000 per Injury or Sickness in conjunction with any one surgical procedure.

- **Surgical Expense** means charges by a Doctor for: (a) a Surgical Procedure; (b) necessary pre-operative treatment during a Hospital stay in connection with such procedures; and (c) usual post-operative treatment.

Surgical Procedure means: (a) a cutting procedure; (b) suturing of a wound; (c) treatment of a fracture; (d) reduction of a dislocation; (e) radiotherapy; (f) electrocauterization; (g) diagnostic and therapeutic endoscopic procedures; (h) injection treatment for hemorrhoids and varicose veins; (i) an operation by means of a laser beam.

- **Multiple Surgical Procedures Expense Benefit**

When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charges of the most expensive Surgical Procedure being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50 percent of the Covered Percentage of the Covered Charge for these procedures.

- **Anesthetist Expense**

If, in conjunction with such operation, the Insured Person requires the services of an anesthetist, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers. The Expense incurred will be included with the maximum under the Surgical Expense.

- **Assistant Surgeon Expense**

If, in conjunction with such operation, the Insured Person requires the services of an assistant surgeon, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers. The Expenses incurred will be included with the maximum under the Surgical Expense.

- **Second Surgical Opinion Consultation Expense**

We will also provide benefits to an Insured Person for a second opinion consultation by a board certified specialist for a non-emergency surgery which has been recommended by the Insured Person's Doctor, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers up to a maximum of \$125.00 per Injury or Sickness. The Specialist must be board certified in the medical field relating to the surgical procedure being proposed. Benefits will be provided for any required X-rays and diagnostic tests done in connection with that consultation.

OUTPATIENT BENEFITS

- **Outpatient Miscellaneous Expense**

Covered Charges for "Outpatient Services" are charges for the following services: (a) Doctor's office while not Hospital Confined; (b) chiropractic care; (c) Hospital outpatient department or emergency room; (d) diagnostic x-ray and laboratory testing; (e) blood and blood services, if provided and billed by a Hospital or other facility; (f) physical and occupational therapy; (g) radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy; (h) radiological lab or other similar facility licensed by the state; (i) surgical dressings, splints, casts, and other devices used to correct fractures and dislocations. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense for Non-Network Providers up to a maximum of \$2,000 per Injury or Sickness per policy year, subject to the copayments below.

Doctor Office Visit	\$15.00 per visit
Hospital Outpatient Department	\$15.00 per visit
Hospital Emergency Room	\$100.00 per visit
	(Reduced to \$50.00 if admitted)

- **High Cost Procedure Expense**

High Cost Procedures, as used herein, means an outpatient procedure costing over \$200.00. Covered Charges for "High Cost Procedures" include, but not limited to, charges for the following procedures and services. (1) C.A.T. Scan; (2) Magnetic resonance imaging; and (3) Laser treatment. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers up to \$2,000 per Injury or Sickness per

policy year. If, by reason of similar benefit provision elsewhere contained, the Policy provides reimbursement for the same changes, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of the Policy.

If the Outpatient Services are in connection with surgery and the Doctor is the surgeon who performed or is to perform the surgery, no benefits are payable under this provision. All surgery charges are paid under the Surgical Expense Benefits provision.

For services normally provided without charge by this Policyholder's health service, infirmary, or Hospital, or by Health Care Providers employed by this Policyholder, no benefits are payable under this Outpatient Expense Benefit provision.

- **Ambulance Expense**

When, by reason of an Injury or Sickness, an Insured Person requires the use of a community or hospital ambulance. We will pay 80% of the Reasonable and Customary Expense incurred up to a maximum of \$250.00 per Injury or Sickness.

- **Voluntary Termination of Pregnancy Expense**

If, as a result of pregnancy having its inception during the term insured, an Insured Person has a voluntary termination of pregnancy, We will pay 100% of Preferred Allowance for Network Providers and 80% of the Reasonable and Customary Expense for Non-Network Providers up to \$350.00 maximum. Expenses for the voluntary termination of pregnancy must be incurred while the Plan is in force as to the Insured Person.

ALCOHOL AND DRUG ABUSE EXPENSE BENEFITS

If an Insured person requires treatment on account of alcoholism, alcohol abuse, drug abuse or drug dependence, we will pay for such treatment as follows:

- **Benefits for Inpatient Confinement**

When the Insured Person is confined for inpatient treatment, We will provide expenses for treatment in an accredited or licensed hospital, public or private facility, or residential alcohol treatment program providing services for the detoxification or rehabilitation of intoxicated persons or alcoholics which is licensed by the Department of Public Health. We will pay 100% of the Preferred Allowance for Network Providers or 80% of Reasonable and Customary Expense for Non-Network Providers incurred for such Hospital Confinement on the same

basis as any other Sickness, but payment will not be made for more than 30 days in a Plan Year.

If charges are incurred in connection with a Mental Illness, the above limits will not apply.

Where medically appropriate, two days of outpatient day treatment may be submitted for one day of inpatient Hospital care.

- **Benefits for Outpatient Services**

We will pay 100% of the Preferred Allowance for Network Providers and 80% of Reasonable and Customary Expense for Non-Network Providers incurred for covered outpatient services for the rehabilitation of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient benefits include services furnished by: (a) an accredited or licensed Hospital; (b) a public or private facility provided services for the rehabilitation of alcoholics licensed by the Department of Public Health; and (c) a licensed Doctor or psychologist.

- **Alcohol Abuse.** This term means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility. This term means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social, and emotional needs of the individual by: (a) monitoring the amount of alcohol and other toxic agents in the body of the individual; (b) managing withdrawal symptoms; and (c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol or Drug Abuse.

Psychotherapist. This term means a person fully licensed to practice medicine and who devotes a substantial portion of his time to practice psychiatry.

DENTAL CARE EXPENSE BENEFITS

- **Accidental Dental Expense**

We will pay the Reasonable and Customary Expense incurred for dental treatment as a result of accidental Injury to sound natural teeth up to a maximum of \$1,000 per Injury.

- **Sickness Dental Expense**

If an Insured Person requires the services of a Doctor for the removal of impacted wisdom teeth, We will pay the Reasonable and Customary Expense incurred up to a maximum of \$100.00 per tooth.

OUTPATIENT PRESCRIPTION DRUG EXPENSE

The outpatient prescription drug benefit is available through the Medco Pharmacy Network. The Medco Network includes national pharmacy chains, CVS, Walgreens, Brooks, etc. as well as local independent pharmacies. After a per prescription copayment of \$10.00 for a 30 day supply of a generic drug or a per prescription copayment of \$25.00 for a 30 day supply of a brand name drug, the Expenses incurred for the cost of prescription drugs will be reimbursed at 100%, up to a maximum of \$1,000 per policy year. Insured Persons will be given an ID card to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving an ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained from Koster Insurance Agency). A listing of Medco Participating Pharmacies is available by calling 1-800-711-0917 or by viewing www.medcohealth.com. Not all medications are covered. (See Exclusion Section).

STUDY/TRAVEL ABROAD

Whether studying or traveling abroad, the Student Health Insurance Plan provides the same benefits as if you were on campus, in addition to Repatriation of Remains Expense Benefit, Emergency Medical Expense Benefit and Travel Assistance Services. These services are coordinated through *On Call International*, the 24-hour worldwide assistance service. When studying or traveling abroad, keep your identification card with you and take a copy of the brochure for reference. When outside of the United States, you will likely be asked to pay for your medical care first and then will need to seek reimbursement. Covered Expenses will be reimbursed on a Non-Network basis. When you submit claims for reimbursement, you will need to have the itemized bill(s) translated into English and include a letter informing the claims administrator that you are seeking reimbursement for charges previously paid. Please insure that your name, ID number, address (to receive your reimbursement check), and the College's name are on the bill.

REPATRIATION OF REMAINS EXPENSE BENEFIT

This benefit applies only to Domestic Students studying or traveling abroad and International Students and their Dependents. In the event of the death of an Insured Person, The Plan will pay the actual charges incurred up to the \$35,000 Per Condition Maximum for

preparing and transporting that person's remains to his or her home country. This will be done in accord with all legal requirements in effect at the time the body remains are to be returned to his or her home. The death must occur while the person is insured for this benefit. Repatriation of remains must be approved in advance by the Company.

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

This benefit applies only to Domestic Students studying or traveling abroad and International Students and their Dependents. The Plan will pay benefits for the Reasonable and Customary Expense incurred up to the \$35,000 Per Condition Maximum, if any Injury or Sickness results in the Emergency Evacuation of the Insured Person.

Emergency Evacuation means: after being treated at a local Hospital; the Insured Person's medical condition warrants transportation to his/her home country to obtain further medical treatment to recover.

Covered Expenses are expenses for transportation, medical services and medical supplies necessarily incurred in connection with an Emergency Evacuation of the Insured Person. All transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company.

Transportation means any land, water or air conveyance required to transport the Insured Person during an Emergency Evacuation. Expenses for special transportation must be: (a) recommended by the attending physician; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to; air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Doctor.

TRAVEL ASSISTANCE SERVICES

Included in this health insurance program is access to a 24-hour worldwide assistance network for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.

3. Urgent message relay between family, friends, personal physician, school, and insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations and repatriations.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact *On Call International* for any of these services:

Toll Free from U.S. and Canada: 1-800-850-4556

Dial Direct or Call Collect Worldwide: 1-603-898-9159
or www.oncallinternational.com

NURSE LINE

Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. ON CALL provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in the Student Accident and Sickness Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives Insured students access to a toll-free nurse information line 24-hours a day, 7 days a week. To access a wealth of useful health care information, contact the Nurse Advice Line at 1-800-850-4556.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Principal Sum referred to in this provision is shown in the Plan of Insurance.

When, because of an Injury, the Insured Person suffers any of the following Losses within 180 days from the date of the Accident, We will pay as follows:

For the Loss Of:	Principal Sum
Life	\$5,000
Two hands	\$5,000
Two feet	\$5,000
Sight of two eyes	\$5,000
One hand and one foot	\$5,000

One hand and sight of one eye	\$5,000
One foot and sight of one eye	\$5,000
One hand or one foot or one eye	\$2,500
Thumb and index finger of either hand	\$2,500

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. Loss of thumb and index finger means actual severance through or above the metacarpophalangeal joints.

Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies.

This provision does not cover the Loss if it in any way results from or is caused or contributed: (1) By physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy; (2) By an infection, unless it is caused solely and independently by a covered Accident; (3) For Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or (4) While the Insured Person is legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.

In addition to the above, this provision is subject to the Exclusions as provided.

STATE MANDATED BENEFITS

- Bone Marrow Transplant for Treatment of Breast Cancer Expense:** If an Insured Person has metastatic breast cancer, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers up to the Aggregate Maximum for the expense of a bone marrow transplant for the treatment of breast cancer.
- Cancer Clinical Trials Expense:** We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for Patient Care Service to an Insured Person engaging in a cancer clinical trial, as a result of: (a) treatment provided for a life-threatening condition; or (b) prevention, early detection, and treatment studies on cancer.
- Cardiac Rehabilitation Expense:** If an Insured Person requires Cardiac Rehabilitation treatment in connection with documented cardiovascular

disease, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses. We will pay for such treatment on the same basis as any other Sickness. Such treatment shall include, but is not limited to, outpatient treatment which is to be initiated within 26 weeks after the diagnosis of such disease.

- **Cytological Screening Expense:** We cover charges for a Cytologic Screening (Pap smear) for an Insured Person 18 years of age or older. After a \$15.00 copayment, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense for Covered Charges incurred for Non-Network Providers for one annual Cytologic Screening, or more frequently if recommended by a Doctor. Such benefit will include the examination, laboratory fee and the Doctor's interpretation of the laboratory results.
- **Diabetes Diagnosis and Treatment Expense:** We will pay 100% of the Preferred Allowance for Network Providers and 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for the diagnosis and treatment of Diabetes if prescribed by a health care professional legally authorized to prescribe the following Medically Necessary items: a) insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes; b) blood glucose monitors; c).blood glucose monitoring strips for home use; d) voice synthesizers for blood glucose monitors for use by the legally blind; e) visual magnifying aids for use by the legally blind, urine glucose strips, ketone strips; f) lancets; g) insulin; h) insulin syringes; i) prescribed oral diabetes medications that influence blood sugar levels; j) laboratory tests, including glycosylated hemoglobin, or HbA1c, test; k) urinary protein/microalbumin and lipid-profiles; l) insulin pumps and insulin pump supplies; m) insulin pens; so-called; n) therapeutic/molded shoes and inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and insets have been certified by the treating Doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, posthetist or pedorthist; o) supplies and equipment approved by the Federal Drug Administration for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a Certified Diabetes Health Care

Provider participating with the insurance contract or affiliated with a provider participating with the insurance contract.

Certified Diabetes Health Care Provider means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

- **Early Intervention Services Expense:** We will pay 80% of the Expense actually incurred up to a maximum of \$5,200 per policy year and \$15,600 over the total enrollment for Early Intervention Services. These services include occupational, physical, speech therapy; nursing care and psychological counseling. Expenses are payable for a dependent child of an Insured Person from birth until their third birthday.
- **Hearing Screening Test Expense:** We cover charges for a newborn Hearing Screening Test to be performed before the newborn infant is discharged from the Hospital or birthing center. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.
- **Hearing, Speech and Language Disorders Expense Benefit:** We cover charges for the medically necessary diagnosis and treatment of speech, hearing and language disorders when recommended and treated by a duly licensed audiologist or speech-language pathologist. Covered charges do not include the diagnosis or treatment of speech, hearing or language disorders in a school-based setting. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.
- **Hospice Care Treatment Expense:** We pay for charges made by a licensed hospice for the Covered Expenses for an Insured Person with a life expectancy of six months or less. Services must be authorized by a duly licensed physician. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.
- **Human Leukocyte Antigen Testing Expense:** We cover charges for Human Leukocyte Antigen Testing or Histocompatibility Locus Antigen Testing necessary to establish bone marrow

transplant donor suitability. Coverage shall include testing for A, B, or DR antigens, or any combination thereof, consistent with the guidelines, criteria, and rules or regulations established by the Department of Public Health. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.

- **Infertility Expense:** If an Insured Person incurs medically necessary expenses for diagnosis and treatment of infertility, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses. Covered Charges include expense incurred for the following non-experimental infertility procedures; (1) Artificial Insemination; (2) In Vitro Fertilization and Embryo Placement; (3) 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; (4) Gamete Intra-Fallopian Transfer; (5) Intracytoplasmic Sperm Injection for the treatment of male factor infertility; and (6) Zygote Intrafallopian Transfer. The term "Infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.
- **Mammography Examination Expense:** We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for a mammographic exam. The charges must be incurred while the Insured Person is insured for these benefits. Benefits will be paid for mammographic exam charges incurred for the following: (a) one baseline mammogram for a woman thirty-five through thirty-nine years of age; and (b) one mammogram every twelve months for a woman forty years of age or older.
- **Maternity Expense:** We will pay benefits for an Insured Persons' Covered Charges for maternity care, including Hospital, surgical, and medical care. We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital.

We will pay for post-delivery care which includes but not limited to home visits, parent education,

assistance and training in breast or bottle feeding, the performance of any necessary and appropriate clinical tests, provided the first home care visit is conducted by a registered nurse, Doctor, or by a certified nurse midwife under qualified medical director if he or she is affiliated with or practicing in conjunction with a licensed health care provider. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses.

- **Mental Illness Expense Benefits**

- **Inpatient Mental Illness Expense Benefit:** When an Insured Person requires hospital confinement for the treatment of a Mental Illness, We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers. But, We will not cover more than 60 days per policy year for such inpatient care. Inpatient benefits are covered if provided in: (a) a mental hospital under the direction and supervision of the Department of Mental Health, or (b) in a private mental hospital licensed by the Department of Mental Health, or (c) a general hospital licensed to provide such services. If charges are incurred in connection with treatment for alcoholism, the above limits will not apply.

Intermediate Services Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred for Intermediate Services including but not limited to Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Department of Public Health or the Department of Mental Health. Where medically appropriate, a period of confinement may be calculated by substituting two days of outpatient treatment at a community mental health center or other mental health clinic or psychiatric day treatment center licensed by the Department of Public Health, or two days of outpatient day treatment at a psychiatric hospital licensed by the Department of Public Health, for one day of inpatient hospital care.

We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses incurred

for Intermediate Services including but not limited to Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Department of Public Health or the Department of Mental Health. Where medically appropriate, a period of confinement may be calculated by substituting two days of outpatient treatment at a community mental health center or other mental health clinic or psychiatric day treatment center licensed by the Department of Public Health, or two days of outpatient day treatment at a psychiatric hospital licensed by the Department of Mental Health, for one day of inpatient hospital care.

- **Outpatient Mental Illness Expense Benefit:** When an Insured Person requires outpatient treatment We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such Expenses. However We will not pay more than 24 visits per Policy Year for such outpatient services. No other limitations, Coinsurance, Copayment, Deductibles or other cost sharing may be applied unless such limitations also apply to Expenses for treatment of conditions that are not mental or nervous conditions.

Outpatient services may be provided in the following facilities: (1) licensed hospital; (2) community mental health center; (3) mental health clinic, licensed by the Department of Public Health; (4) psychiatric day treatment center, licensed by the Department of Public Health; (5) professional office, or home-based services provided by the following licensed mental health professionals acting within the scope of his or her license: (a) a licensed Doctor who specializes in the practice of psychiatry, (b) a licensed psychologist or licensed Psychotherapist; (c) a licensed independent clinical social worker, a licensed mental health counselor, or (d) a licensed nurse mental health clinical specialist. If charges are incurred in connection with treatment for alcoholism, the above limits will not apply.

Psychotherapist means a person fully licensed to practice medicine and devote a substantial portion of his time to the practice of psychiatry.

- **Specific Mental Disorders Expense Benefit**

- **Biologically Based Mental Disorders**

(a) schizophrenia; (b) schizoaffective disorder; (c) major depressive disorder; (d) bipolar disorder; (e) paranoia and other psychotic disorders; (f) obsessive-compulsive disorder; (g) panic disorder; (h) delirium and dementia; (i) affective disorders; and (j) any biologically-based mental disorders appearing in DSM that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance. We will pay 100% of the Preferred Allowance for Network Providers and 80% of Reasonable and Customary Expenses incurred for Non-Network Providers for such Expenses.

- **Rape Related Mental or Emotional Disorders**

We cover the diagnosis and treatment of rape-related mental or emotional disorder to victims of rape or victims of an assault with intent to commit rape, whenever the cost of the diagnosis and treatment exceed the maximum compensation awarded to the victim under the crime victim's compensation law. We cover such charges the same way We treat Covered Charges for any other Sickness.

- **Non-Biologically Based Mental, Behavioral or Emotional Disorders that substantially limit the functioning and social interactions of children and adolescents under the age of 19:**

We cover charges for the diagnosis and treatment of which substantially interfere with or substantially limit the functioning and social interactions of a child or adolescent provided that the interference or limitation is documented and referred for treatment by a Doctor, a primary pediatrician or a licensed mental health professional, or be evidenced by conduct including, but not limited to an inability to attend school as a result of the disorder, the need to hospitalize the child or adolescent as a result of the disorder, or a pattern of conduct caused by the disorder that poses a serious danger to self or others. Treatment may continue beyond the adolescent's 19th birthday until the course of treatment is completed, provided the plan under which the benefits first became available remains in effect, or are subject to a subsequent health plan that is in effect. We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and

Customary Expense incurred for Non-Network Providers for such Expenses.

- **Psychopharmacological Services and Neuropsychological Assessment Services**

Services must be treated as medical benefits and must be covered to the same extent as all other medical services.

Benefits will be subject to deductibles, coinsurance, plan maximums and other policy provisions, the same as any other illness. The complete description of each can be found in the Master Policy on file at the College.

- **Non-prescription Enteral Formulas Expense:**

We will pay 100% of the Preferred Allowance for Network Providers or 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for such up to \$2,500 per policy year for benefits for non-prescription enteral formulas which are medically necessary for the treatment of malabsorption caused by Crohn's Disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited disease of amino acids and organic acids.

- **Outpatient Hormone Replacement Therapy and Contraceptive Services Expense:**

We will pay 100% of the Preferred Allowance for Network Providers and 80% of the Reasonable and Customary Expense incurred for Non-Network Providers for Outpatient Hormone Replacement Therapy Services for pre and post-menopausal women and Outpatient Contraceptive Services up to \$750.00. Outpatient Contraceptive Services includes 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 U.S.D.A.

- **Preventive and Primary Care Expense for Children:**

We will pay 80% of the Actual Expense incurred for preventive and primary care expenses. These are for services rendered to a dependent child of an Insured Person from the date of birth through the attainment of six years of age. These services are limited to the following: physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the next year,

annual until age six. Such services will 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 Doctor.

- **Scalp Hair Prosthesis Expense:** We cover charges for Scalp Hair Prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. We cover such charges up to a maximum of \$1,000 in a Plan Year. Coverage must be subject to a written statement by the treating Doctor that the Scalp Hair Prosthesis is Medically Necessary.
- **Services Performed By Certified Registered Nurse Anesthetists and Nurse Practitioners Expense:** We pay for services by Nurse Practitioners and Certified Registered Nurse Anesthetists (CRNA) if the service performed is within the scope of the nurse practitioner's authority to practice or the CRNA's license and if the Plan currently provides benefits for identical services rendered by a health care provider licensed in Massachusetts.
- **Special Medical Formulas Expense:** We cover charges for special medical formulas for newborns and adoptive children which are: 1) approved by the Commissioner of the Department of Public Health; 2) prescribed by a Doctor; and 3) are Medically Necessary for the treatment of Phenyketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia or methymalonic acidemia in infants and children; or 4) are Medically Necessary to protect the unborn fetuses of pregnant women with phenylketonuria. Screening for lead poisoning will also be covered.

We cover such charges the same way We treat Covered Charges for any other Sickness.

EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth;
2. Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, and contact lenses (except when required after cataract surgery), other vision or hearing aids,

- except as required for repair caused by a covered Injury;
3. Injury due to participation in a riot;
 4. Injury or Sickness from any declared or undeclared war, or any act thereof;
 5. Accident occurring in consequence of 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 scheduled airline maintaining regularly published schedules on a regularly established route;
 6. Injury or Sickness for which benefits are payable under the Occupational Disease Law or Workers' Compensation;
 7. Injury sustained or Sickness contracted while in service of the Armed Forces of any country. Upon the Insured Person entering the Armed Forces of any Country, We will refund the unearned pro-rated premium to such Insured Person;
 8. Treatment in a government hospital unless there is a legal obligation to pay such charges in the absence of insurance;
 9. Elective treatment or elective surgery, except as specifically provided;
 10. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
 11. Injury resulting from a motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;
 12. Services normally provided without specific charge by the Health Services, or by Health Care Providers employed by Berklee College of Music;
 13. For services, supplies or treatment; including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a physician; or expenses non-medical in nature;
 14. Expense incurred after the date of insurance terminates for an Insured Person except as may

be specifically provided in the Extension of Benefits Provision;

15. For services rendered by a Doctor who is a close relative to the Insured Person. By “close relative” We mean an Insured Person’s spouse, children, parents, brothers or sisters;
16. Pre-existing Conditions as defined in this Plan, not to exceed \$1,500 per Injury or Sickness for a six month period;
17. Expense incurred for: tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; and learning disabilities or disorders or Attention Deficit Disorder;
18. Treatment of mental illness disorders except as specifically provided;
19. Treatment of alcohol and substance abuse except as specifically provided;
20. Routine periodical physical examinations, except as specifically provided;
21. Preventative medicine, serums, immunizations, or vaccine, except as specifically provided;
22. Well baby care, including routine exams and immunizations, except as specifically provided;
23. Expenses incurred for: immunizations, vitamins or food supplements except as otherwise covered, smoking deterrents, biological sera, blood plasma, drugs to promote or stimulate hair growth, experimental drugs and drugs dispensed in a hospital or rest home;
24. Services not Medically Necessary;
25. An amount of a charge in excess of the Reasonable and Customary Expense;
26. Illness, Accident, treatment or medical condition arising out of the play or practice of intercollegiate sports;
27. For expenses as a result of participation in a felony.
28. Sickness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungicord jumping;
29. Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;

30. Foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, calluses, routine care of toenails, and the like, except for treatment of bunions, capsular, or bone surgery, and infected and impacted toenails, which are covered when Medically Necessary;
31. Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;
32. Expense covered by any other valid and collectible medical, health or accident insurance, in excess of \$100.00.

REIMBURSEMENT & SUBROGATION

If We pay covered expenses for an accident or injury You incur as a result of any act or omission of a third party, and You later obtain recovery from the third party, You are obligated to reimburse Us for the expenses paid. We may also take subrogation action directly against the third party. Our Reimbursement rights are limited by the amount You recover. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

EXTENSION OF BENEFITS

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the 90 day period following such termination of insurance.

INQUIRY AND GRIEVANCE PROCESS

Inquiry: The Inquiry process is an informal process during which We attempt to answer questions and/or resolve concerns communicated to us on your behalf, within three (3) business days. If We fail to answer your question or resolve your concern, then you may have the Inquiry processed as an internal Grievance. The Inquiry process may not, however, be used for review of an adverse determination (involving medical necessity determinations), which should be resolved as an internal Grievance.

Inquiry Procedure:

- 1) If you have an Inquiry (e.g., a question or concern which has not been the subject of an adverse determination), you should call Klais & Co., Inc. (Our

Administrator) and speak with a Customer Service Representative. You may reach customer service at Klais & Co., Inc. by calling: (800) 331-1096. We will attempt to resolve your inquiry to your satisfaction within three (3) business days of the Inquiry.

- 2) If We or Our Administrator are unable to explain your Inquiry or resolve your concern to your satisfaction, you may, at your option, have the Inquiry processed as an internal Grievance.

1st level Internal Grievance: If you wish to file a Grievance concerning any aspect or action of your health plan, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations, or if your Inquiry was not resolved to your satisfaction, You may request an internal Grievance. Your duly authorized representative or health care provider may request a Grievance on your behalf, in regard to a specific matter, with proper authorization.

1st level Internal Grievance Procedure:

- 1) You may initiate a 1st level Grievance in a variety of ways. A Grievance may be initiated by telephone, in person, by mail, or by electronic means.
 - a) If you wish to initiate a Grievance by telephone, you should call Klais & Co., Inc. (Our Administrator) at (800) 331-1096 and ask to speak with a Patient Advocate.
 - b) If you wish to initiate a Grievance in person, you may do so by scheduling an appointment with a Patient Advocate. You should call Klais & Co., Inc. (Our Administrator) at (800) 331-1096 to schedule a convenient time to meet with a Patient Advocate at our corporate offices, which are located at 1867 West Market Street, Akron, OH 44313-6977.
 - c) If you wish to initiate a Grievance by mail, it should be mailed to: Patient Advocate, Klais & Co., Inc., 1867 West Market Street, Akron, OH 44313-6977.
 - d) If you wish to initiate a Grievance by electronic means, you may send an E-mail to Klaisclaims@klais.com. We cannot, however, assure the confidentiality of clinical information sent via electronic means.
- 2) We will reduce your oral Grievance to writing and forward a copy of it to you within forty-eight (48) hours of receipt or provide you with written acknowledgment of your written Grievance within fifteen (15) business days of receipt.
- 3) We will issue a written determination of your

Grievance within twenty (20) business days of receipt of the Grievance, and a signed release, if necessary, to obtain pertinent medical records. Our Grievance determination will be sent to you in writing. It will include substantive clinical justification for the decision.

- 4) You will receive an expedited resolution to your Grievance in the following situations: (a) If you are hospital confined, Your Grievance will be resolved before you are discharged from the hospital; (b) If you have been denied services or durable medical equipment (“DME”), your physician may invoke the option for an automatic reversal of the decision denying coverage, pending the outcome of the Grievance process, within forty-eight (48) hours (or earlier for DME) of receipt of certification by Your Doctor that: the service or DME at issue in a Grievance is Medically Necessary; the denial of coverage would create a substantial risk of serious harm to the patient; and that the risk of serious harm is so immediate that the provision of such service or DME should not await the outcome of the normal Grievance process. If Your Doctor exercises the option of automatic reversal earlier than forty-eight (48) hours for DME, then he or she must further certify as to the specific, immediate and severe harm that will result to the patient absent action within the forty-eight (48) hour time period; (c) If you are terminally ill and have submitted a Grievance, it shall be resolved within five (5) business days from the receipt of the Grievance. If the expedited review affirms denial of coverage or treatment, you (or your duly authorized representative) will receive within five (5) business days of the decision a statement from Us setting forth the specific medical and scientific reasons for denying coverage or treatment and a description of alternative treatment, services or supplies covered or provided, if any. In addition, you (or your duly authorized representative) may request a conference. The conference will be scheduled within ten (10) days (or within five (5) business days of the request, if the treating Doctor determines that the effectiveness of either the proposed or alternative treatment would be materially reduced if not provided at the earliest possible date.) You, Your authorized representative, or both may attend the conference.

2nd level Internal Grievance (Optional): If you are not satisfied with the 1st level Grievance determination, you (or your duly authorized representative) may request a 2nd level internal Grievance. A 2nd level internal Grievance must be requested within 45 days of

receipt of the 1st level Grievance determination.

- 1) You may initiate a 2nd level Grievance by contacting your Patient Advocate by telephone, in person, by mail, or by electronic means by following the same process to initiate a 1st level Grievance, as explained above.
- 2) We will reduce your oral Grievance to writing and forward a copy of it to you within forty-eight (48) hours of receipt, or provide you with written acknowledgment of a written Grievance within forty-eight (48) hours of receipt.
- 3) We will issue a written determination of your Grievance within ten (10) business days of receipt of the request for a 2nd level Grievance, provided that We have a signed release, if necessary, to obtain medical records. The determination will include substantive clinical justification for the decision.
- 4) You will receive an expedited resolution to your 2nd level Grievance for the same situations that require an expedited resolution for a 1st level Grievance. The expedited 2nd level Grievance will be resolved within forty-eight (48) hours.
- 5) You (or your duly authorized representative) may appear before the committee or communicate with the committee by conference call or other means.

Other information regarding the Internal Grievance Process:

- 1) Any 1st level Grievance not properly acted upon within thirty (30) business days or the time limits established for an Expedited Review shall be deemed resolved in favor of the insured. Time limits include any extensions made by mutual written agreement. You will be asked to sign a form extending this thirty (30) day period in order to proceed with the 2nd level internal Grievance process.
- 2) Grievances will be reviewed by an individual or individuals who are knowledgeable about the matters at issue in the grievance process.
- 3) Grievances of adverse determinations will be reviewed with the participation of an individual(s) who did not participate in any of the prior decisions on the Grievance. In at least one level of review of grievances of adverse determinations, these individuals shall be actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure or provide the treatment which is the subject of the Grievance.
- 4) When a grievance requires review of medical records, the thirty (30) business day period will not begin to run until the insured submits a signed

authorization for release of medical records. With regard to a Grievance that follows an Inquiry, the thirty (30) day time period begins on the day immediately following the three (3) business day period for processing an Inquiry (if the grievance does not require the review of medical records), or on the day the insured notifies Us that he or she is not satisfied with the response to the Inquiry.

- 5) We may issue a resolution within thirty (30) business days if We are not provided with the signed authorization, or have not received the necessary clinical information. You may request reconsideration of the Grievance when the clinical information is received late, or has not been received, but is expected to become available within a reasonable time period. We may reconsider the Grievance, at our option. If We approve your reconsideration request, We will establish a new period for review, which shall not exceed thirty (30) business days.
- 6) If a Grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect through completion of the internal Grievance process (except for medical care which was terminated pursuant to a specific time or episode-related exclusion.)
- 7) In the case of a Grievance which involves an adverse determination, the written resolution will include a substantive clinical justification that is consistent with accepted principles of professional medical practice, and will at a minimum: (1) Identify the specific information upon which the adverse determination was based; (2) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (3) specify alternative treatment options covered, if any; (4) reference and include applicable clinical practice guidelines and review criteria; and (5) notify the insured of the procedures for requesting external review.
- 8) You may contact the Office of Patient Protection, 250 Washington Street, 2nd floor, Boston, MA 02109 or you may contact them by telephone at (800) 436-7757, via facsimile at (617) 624-5046 or via their internet site at www.state.ma.us/dph/bhqm for assistance with an internal Grievance.

External Review: If you are not satisfied with the 2nd level Grievance determination or you decided not to pursue the 2nd level internal Grievance process, you or your duly authorized representative may request an External Review.

External Review Procedure:

- 1) You may request an External Review by filing a request in writing with the Office of Patient Protection (“OPP”). This must be done within forty-five (45) days of receipt of written notice of the final Grievance determination. You will be required to pay a fee of twenty-five dollars (\$25) to the OPP, which shall accompany your request for an external review. This fee may be waived by the OPP if it determines it will cause an extreme financial hardship.
- 2) You may also request an expedited External Review by including a certification, in writing, from your Doctor, that delay will pose a serious and immediate threat to your health.
- 3) You may apply to the External Review panel to seek the continuation of coverage for terminated services during the period the review is pending. The review panel may order the continuation of coverage or treatment when it determines that substantial harm to the insured’s health may result absent such continuation or for other good cause as the review panel shall determine.
- 4) You may write to the Office of Patient Protection, 250 Washington Street, 2nd floor, Boston, MA 02108 or you may contact them by telephone at (800) 436-7757, via facsimile at (617) 624-5046 or via their internet site at www.state.ma.us/dph/bhqm.
- 5) Decisions of the External Review panel are binding.

We will provide any reporting requirements to the Office of Patient Protection no later than May 15th of each year.

CLAIMS PROCEDURES

In the event of an Injury or Sickness the Insured Person should:

1. A claim form is not required to submit a claim. However, an itemized bill, HCFA 1500, or UB92 form should be used to submit expenses. If a referral was required, this form should accompany this submission. The Insured Student/Person’s name and identification number need to be included.
2. Providers should submit claims within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. If a student is submitting the claim, a copy should be retained and claims should be mailed to the Claims Administrator, Klais & Company, Inc. at the address on the back cover.
3. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim,

or benefit availability to the Claims Administrator, Klais & Company, Inc.

4. If you disagree with a claim payment decision, an Insured Person has the right to file an appeal. The process to file an appeal is as follows: (a) you must notify Klais & Company, Inc. within 30 days of the denial. Your claim appeal must be in writing, and clearly state that you are appealing the decision and requesting another review of your claim; and (b) your written appeal should provide specific documentation as to why you believe the decision to be in error, and any new medical information that will be helpful to Klais & Company, Inc. in considering the claim. Klais & Company, Inc. will respond in writing as to their decision.

REMEMBER THAT EACH INJURY OR SICKNESS REQUIRES A SEPARATE REFERRAL FORM EACH POLICY YEAR.

Any provisions of this Policy, which on its effective date, is in conflict with the statutes of the state in which the Policy is issued will be administered to conform with the requirements of the state statutes.

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

Under HIPAA's Privacy Rule, We are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your enrollment materials. If, at anytime, you wish to request a copy of Combined Insurance Company of America's Privacy Notice, write to 5050 Broadway, Chicago, IL 60640, Attn: HIPAA Privacy Office or call 1-800-225-4500, select HIPAA.

QUESTIONS? NEED MORE INFORMATION?

For general information on benefits, on enrollment/eligibility questions, ID Cards or service issues, please contact:

Koster Insurance Agency, Inc.

500 Victory Road
Quincy, MA 02171
1-800-457-5599

Email: Berkleestudent@kosterins.com
www.kosterweb.com

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call Koster to verify eligibility.

For information on a specific claim, or to check the status a claim, please contact:

Klais and Company, Inc.

1867 West Market Street
Akron, OH 44313-6977
800-331-1096

Email: Klaisclaims@klais.com OR

Register for StatusLink Claims Look-Up at www.klais.com

For information on participating healthcare providers, please contact:

CCN

888-685-7774

www.ccnusa.com

For information on participating Medco pharmacies, please contact:

MEDCO Pharmacy Network

800-711-0917

www.medco.com

For information on the Eyemed Vision Program, please contact:

EyeMed

1-866-8EYEMED

www.enrollwitheyemed.com

For information on the Dental Savings Plan, please contact:

Basix

www.basixstudent.com

For information on Assist America Travel Assistance Services, please contact:

On Call International

1-800-850-4556 (toll free within the United States)

1-603-898-9159 (collect, outside the United States)

www.oncallinternational.com

This policy is underwritten by:

Combined Insurance Company of America

Policy Number: CUH201175

A Master Policy is available for review at Berklee College of Music. In the event of any conflict between this description of services provided and the Policy, the Master Policy will control.