

**Student Injury
and Sickness
Insurance Plan
Policy Year:
2011-2012**

Designed for



**EASTERN
MENNONITE
UNIVERSITY**

**1200 Park Road
Harrisonburg, VA 22802**

This plan is underwritten by:

**Monumental Life
Insurance Company**
Cedar Rapids, Iowa
an AEGON company

Please visit us on the web for complete details:
www.BollingerColleges.com/EMU

Policy No. CVA209H

Visit us on the web at:
www.BollingerColleges.com/EMU

**THIS PLAN IS SUBJECT TO THE REGULATION IN THE
COMMONWEALTH BY BOTH THE STATE CORPORA-
TION COMMISSION BUREAU OF INSURANCE PUR-
SUANT TO TITLE 38.2 AND THE VIRGINIA DEPART-
MENT OF HEALTH PURSUANT TO TITLE 32.1**

THE NEED FOR PROTECTION AGAINST MEDICAL EXPENSES

Hospitalization, surgery and accompanying medical expenses are at an all time high.

Many students are not prepared to meet the added cost of unexpected Injuries or Sicknesses. Costly medical bills can impose tremendous hardship, and even necessitate withdrawal from school.

The University is vitally concerned with the health and well-being of its students. Student Injury and Sickness Insurance is designed to provide low-cost coverage for unanticipated medical expense.

The Plan described in this brochure is made available as a service to our students. Please read the provisions of this insurance plan carefully and retain this brochure for future reference.

COVERAGE

The plan protects students covered by this insurance at Eastern Mennonite University, at home, at school or while traveling, 24 hours a day for 12 months.

1. Benefits become effective 12:01 a.m. on August 20, 2011 and continue until 12:00 a.m. on August 20, 2012.
2. Protection is in effect during all vacation periods.

REFUND PROVISION

Coverage will remain in force during the period for which premium has been paid even if the student leaves school or obtains other coverage. In the event a student leaves school to enter active military service, coverage will cease and a pro rata refund of premium will be made upon request.

ELIGIBILITY

The plan is available to students taking at least 6 credit hours each semester. Health insurance is an EMU requirement for international students and for students who participate in a varsity sport or in a cross-cultural seminar. EMU strongly encourages other students to consider enrolling in the program. Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Eligible students

may also insure their dependents. Eligible dependents are the spouse and children up to 26 years of age who are not self-supporting. Dependent eligibility expires concurrently with that of the insured student.

ENROLLMENT DEADLINE

Students must submit their waiver form to Eastern Mennonite University prior to September 20, 2011. Dependents must also be enrolled by September 20, 2011.

BASIC PLAN COST

	Annual	Spring/Summer	Summer
Student	\$ 865	\$ 535	\$ 88
Spouse	\$2,295	\$1,427	\$240
Child(ren)	\$ 1,271	\$ 803	\$134

COVERED MEDICAL EXPENSES are Usual, Customary, and Medically Necessary charges that are:

- (1) Not in excess of the maximum amount payable for services as specified in the Schedule;
- (2) In excess of any deductible amount; and
- (3) Incurred while the Covered Person's coverage under the Policy is in force.

DEDUCTIBLE means the dollar amount of Covered Medical Expenses that must be paid as an out-of-pocket expense by each Covered Person each Policy Year before benefits are payable under the Policy. The Deductible Amount is shown on the Schedule. Under certain conditions, the Deductible Amount may be lowered or waived by the Company.

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

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under the Policy. All Injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in death, permanent placement of the Covered Person's health in jeopardy, serious impairment of bodily functions or serious and permanent dysfunction of any body organ or part. Expenses incurred for a medical emergency will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICALLY NECESSARY means care which a Physician has determined to be certifiably essential for the diagnosis or treatment of a Sickness or Injury. This determination must be based on objective results produced by an examination of the Covered Person's demonstrable symptoms. The Physician's treatment plan may be reviewed by an impartial third party whose determination will be binding on us and the Insured.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts or social worker. He must be practicing within the scope of his license for the service or treatment given. He may not be the Insured or a member of his Immediate family. Physician shall also include a Dentist performing covered services within the scope of his professional license.

SICKNESS means an illness, or disease, or trauma related disorder due to Injury which first manifests or causes a loss while this Policy is in force and which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. It also includes pregnancy and complications of pregnancy.

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

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Insured's Pre-existing Conditions. They are defined as an Injury sustained or a Sickness for which the Insured noticed symptoms or was medically diagnosed, treated (including medication), or advised by a Physician within the six months immediately prior to his effective date of coverage under the Policy.

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

1. Twelve consecutive months have elapsed during which no medical treatment or advice is given by a physician for such condition; or
2. The Insured has been insured under the Policy and the University's prior policies for 6 months; or
3. The Insured has been receiving benefits under the University's prior policies and has been continuously insured since the date of accident, Injury, or Sickness, whichever occurs first.

CREDIT FOR PRIOR COVERAGE

The Policy provides portability of coverage as it relates to "Pre-Existing Conditions". The Pre-Existing Condition limitation set forth in the Policy will be reduced to the extent an Insured Person was covered under a Qualifying Previous Coverage if: 1) the person is not a late enrollee; and 2) the prior coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage, exclusive of any applicable waiting period.

CONTINUATION OF COVERAGE

If a Covered student no longer meets the Policy's eligibility requirements, he or she may continue coverage for nine (9) months provided the school renews the Master Policy with Monumental Life Insurance Company. The student must notify us that he or she wishes to continue coverage under this Policy and pay any required premium within thirty (30) days of ineligibility under the Policy's requirement.

If the Insured is hospital confined at the time coverage terminates, the Insured will be allowed to enroll for Continuation of Coverage prior to the date of discharge from the hospital.

MEDICAL EVACUATION BENEFIT

When as a result of a Covered Injury or Covered Sickness, you or your covered dependent is hospitalized for five (5) consecutive days or more, we will pay, upon the recommendation and approval of the attending Physician, for the evacuation of you or your dependent to your natural country, or to a facility operated pursuant to the law for the care and treatment of injured or ill persons, the actual expense incurred, but not to exceed \$10,000 in the aggregate. This benefit is payable in addition to any other benefit of the Policy.

REPATRIATION BENEFIT

(Preparation & Transportation of Remains)

If you or your covered dependent dies while insured under the Policy, we will pay the actual Expense incurred for preparation and transportation to your home country (in accordance with the applicable international requirements) the remains of the deceased's body, but not to exceed \$10,000 in the aggregate. The benefit is payable in addition to any other benefit of the Policy except Accidental Death and Dismemberment.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Accidental Death and Dismemberment Insurance covers you for a Loss as shown below. The Loss must result from an Accidental Injury, directly and independently of all other causes. The Injury must take place while you are an Insured under this Policy. Also, the Loss must take place within fifty-two (52) weeks after the accident.

The following table shows the amounts we will pay:

For Loss Of:	Amount
Life	\$1,000
Both hands or both feet or sight of both eyes	\$1,000
One hand and one foot	\$1,000
One hand and sight of one eye	\$1,000
One foot and sight of one eye	\$1,000
One hand or one foot or sight of one eye	\$500

The most we will pay for all losses as the result of one accident is \$1,000.

Loss to hands and feet means severance at or above the wrist or ankle joints. Loss of sight means total and irrecoverable loss of sight .

BENEFITS SUMMARY

MAXIMUM BENEFIT \$90,000 per person per Injury or Sickness.

SICKNESS DEDUCTIBLE \$200 per person per Policy year.

SCHEDULE OF BENEFITS

Covered Expenses	Benefit Amount
Injury Benefit	70% for the first \$1,000 (\$100 deductible); 70% to \$90,000
Sickness Benefit	Schedule below 70% of the Usual & Customary Charge to \$90,000
<p>Injury and Sickness Benefits: Hospital Outpatient Hospital Room and Board to Semi-Private Rate. Hospital Care for Sickness, Injury or pregnancy related condition. Inpatient Mental Health Services including drug and alcohol Treatment (25 days maximum per Policy year). Partial Day Psychiatric Care Program (10 inpatient days may be converted to a maximum of 15 partial days when Medically Necessary. Pre-cert required.) Ancillaries (Operating Room, Medication, Anesthesia, Lab, X-rays, etc.)</p>	70% of the Usual & Customary Charge to \$2,500
<p>Physician's Care Inpatient and Outpatient: Physician Outpatient Care for accidental Injury, surgery, radiological therapy, chemotherapy (not oral), medical Emergencies, and necessary office and home visits. Pre-Natal and Post-Natal Care, Including Delivery. Surgical, Surgical Assistant, Obstetrical, Pathological, Consultative, Lab and Radiological Services.</p>	70% of the Usual & Customary Charge

<p>Inpatient Mental Health Services including drug and alcohol Treatment (25 days maximum per Policy year).</p> <p>Outpatient Mental Health Services including drug and alcohol Treatment.</p> <p>(Note: any visits where the total allowed amounts have been applied to the Deductible, do not apply to the 20 visit maximum.)</p>	<p>70% of the Usual & Customary Charge for the first 5 visits; then 50% for the next 15 visits: up to maximum of 20 visits.</p>
<p>Other Benefits:</p> <p>Emergency Room</p> <p>Mammography Screening (One baseline for women age 35-40, then annually)</p> <p>Outpatient Therapy (Spinal Manipulation \$500 per Policy year)</p> <p>Pap Smear (Limited to one per Policy year)</p> <p>Prostate Specific Antigen (Limited to one per Policy year).</p> <p>Digital Rectal Examinations (One per Policy year over age 50, or age 40 if high risk for prostate cancer).</p> <p>Home Health- durable medical equipment, and the cost of blood, blood plasma, blood derivatives and early intervention services.</p> <p>Early intervention services do not apply to Policy year maximum. Early intervention services for covered dependents from birth to age 3. \$5,000 Policy year maximum.</p>	<p>70% of the Usual & Customary Charge to \$2,500</p>
<p>Prescription Drugs</p>	<p>100% of the Usual & Customary Charge to \$250</p>

NON-DUPLICATION OF BENEFITS

The Policy provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by any Other Valid and Collectible Insurance. If the Covered Person is covered by Other Valid and Collectible Insurance, all benefits payable by such insurance will be determined before benefits will be paid by the Policy. The Policy is the second payor to any other insurance having primary status or no Coordination or Non-Duplication of benefits provision.

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

Benefits paid by the Policy will not exceed: (1) any applicable Policy maximums; and (2) 100% of the compensable expenses incurred when combined with benefits paid by any Other Valid and Collectible Insurance.

OPTIONAL MAJOR MEDICAL BENEFIT

Eligibility: All registered students taking at least 6 credit hours each semester are eligible to purchase the Optional Major Medical Benefit. This coverage is optional. Students who elect to purchase this option must have purchased the basic Plan as well.

Term of Coverage: Students who elect to purchase the Optional Major Medical Benefit must submit the enrollment form and premium to Bollinger, Inc. with a postmark date prior to the school's effective date of coverage, August 20, 2011.

Coverage is available to registered students taking at least 6 credit hours each semester who elect to purchase it. The additional premium for this coverage is noted on the enrollment form.

If the Covered Medical Expenses for an Injury exceed the maximum under the basic Injury benefit (\$90,000), payment will be made for 70% of the remaining covered Injury expenses (\$110,000). If the Covered Medical Expenses for a Sickness exceed the maximum under the basic Sickness expense benefit (\$90,000), payment will be made for 70% of the remaining covered Sickness expenses (\$110,000), up to a maximum of \$200,000. The combined maximums under the basic plan and the Optional Major Medical Benefit will not exceed \$200,000.

The total benefits payable for all Policy terms for which you are enrolled for the Optional Major Medical Benefit will not exceed \$200,000 for any one Injury or Sickness.

COST (Supplemental Plan)

Students under age 25.....\$303

Students age 25 and over.....\$425

Covered Medical Expenses under this coverage will be the same as Covered Medical Expenses under the basic Plan. All other terms and conditions of the Plan will apply to this coverage as well.

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid under the Policy for any expenses which result from:

- Expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to natural teeth;
- Services that are provided normally without charge by the University's health center, infirmary or Hospital; or by any person employed by the University;
- Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except as required for repair caused by a covered Injury;
- Routine physical examinations, preventive testing or treatment, screening exams or testing in the absence of Sickness or Injury, pre-marital examinations, pre-employment examinations, health examinations or pre-school physical examinations including routine care of a newborn infant, well baby nursery and related Physician charges, other than Hospital nursery expense of a newborn baby, and any associated laboratory work, not including mammograms and routine Papanicolaou cytology test;
- Cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment within 24 hours of the accident. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of the Policy;
- Expenses for Preventative Medicines, Vaccines, or Prescription Drugs or Injections administered during an outpatient visit, except an injection given by a physician in private practice who will certify that a Medical Emergency was required for the condition (this does not apply to child immunizations);

- Elective abortion;
- Declared or undeclared war, riot, civil disorder, civil commotion or acts of terrorism;
- Committing or attempting to commit an assault or felony; or fighting, except in self- defense;
- Suicide or attempted suicide while sane or insane, including drug overdose; or intentional self-inflicted Injury (except in Colorado and Missouri, while sane);
- Injury sustained or Sickness contracted while in the service of the armed forces of any country. When an Insured enters the armed forces, we will refund any unearned pro-rata premium with respect to such person;
- Injury or Sickness for which benefits are payable under any Worker's Compensation or Occupational Disease Law;
- Injury sustained or Sickness contracted as a result of the use of alcohol or the misuse of drugs, medicines, or narcotics, unless taken in the dosage and for the purpose prescribed by the Covered Person's Physician;
- Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance; and
- Elective Surgery or Elective Treatment.

MANDATED BENEFITS

The Plan will pay for the following mandated benefits and any other applicable mandate in accordance with Virginia insurance laws:

Autism Spectrum Disorder

Coverage will be provided for the diagnosis and treatment of Autism Spectrum Disorder for covered Dependents from age two through age six, subject to the annual maximum benefit stated in the Schedule of Benefits. At our expense, we may request a review of that treatment not more than once every 12 months unless we and the covered Dependent's licensed physician or licensed psychologist agree that a more frequent review is necessary.

The maximum annual limit of coverage is \$5,000 but shall not be subject to any limits on the number or visits to a service provider.

For purposes of this benefit, the following definitions apply:

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder means any pervasive developmental disorder, including

1. autistic disorder,
2. Asperger's Syndrome,
3. Rett syndrome,
4. childhood disintegrative disorder, or
5. Pervasive Developmental Disorder - Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Behavioral Health Treatment means professional, counseling, and guidance services and treatment programs, including applied behavior analysis when provided or supervised by a board certified behavior analyst, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

Diagnosis Of Autism Spectrum Disorder means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

Medically Necessary means based upon evidence and reasonably expected to do any of the following:

1. prevent the onset of an illness, condition, injury, or disability;
2. reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
3. assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

Pharmacy Care means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic Care means services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or clinical social workers.

Treatment For Autism Spectrum Disorder shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

1. behavioral health treatment,
2. pharmacy care,
3. psychiatric care,
4. psychological care, and
5. therapeutic care.

Treatment Plan means a plan for the treatment of autism spectrum disorder developed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

Benefits will be provided on the same basis as any for any other Sickness. Benefits are subject to all co-payments, deductibles and limitations of the Policy.

Biological Based Mental Illness Benefit

Benefits will be provided at the same level as any other Sickness for Biologically Based Mental Illness.

Biologically Based Mental Illness means any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as Biologically Based Mental Illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Bones and Joint Treatment Benefit

We will provide benefit for the diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw required because of a medical condition or Injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part. Benefits will be paid at the same level as any other Sickness.

Cancer Clinical Trial Benefit

Benefits will be provided at the same level as any other Sickness for reimbursement for the routine patient costs incurred by a Covered Person during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials. In order to be eligible for this coverage, a cancer clinical trial shall be approved by: 1) The National Cancer Institute (NCI); or 2). An NCI cooperative group or an NCI center; or 3) The federal Food and Drug Administration in the form of an investigational new drug application; or 4). The federal Department of Veterans Affairs; or 5). An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

Coverage of patient care costs will apply only if:

1. There is no clearly superior, non-investigational treatment alternative;
2. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and
3. The Covered Person and the Physician or health care provider who provides services to the Covered Person, conclude that participation in the clinical trial would be appropriate, pursuant to procedures established by Us as disclosed in this Policy and evidence of coverage.

Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established National Institute of Health (NIH) approved peer review program operating within the group. Cooperative Group includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relation-

ship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

Patient Cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the member for purposes of a clinical trial. Patient Cost does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

Colorectal Cancer Screening Benefit

Benefits will be payable for a Covered Person who incurs expenses for colorectal cancer screening for the detection of colorectal cancer. Coverage will be provided for the ages, family histories and frequencies in accordance with the latest screening guidelines issued by the American Cancer Society. Coverage will be provided for:

1. Yearly fecal occult blood test (FOBT);
2. Flexible sigmoidoscopy or colonoscopy;
3. Radiologic imaging in accordance with the most recently published recommendations established by the American College of Gastroenterology in consultation with the American Cancer Society.

Cytology/Pap Smear Benefit

Benefits will be provided at the same level as any other Sickness for annual pap smears, including coverage for annual testing performed by an FDA approved gynecologic cytology screening technologies.

Dental Anesthesia Benefit

Benefits will be payable for Medically Necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a Covered Person who is:

1. determined by a licensed dentist in consultation with the Covered Person's treating Physician to require general anesthesia and admission to a Hospital or outpatient surgery facility to effectively and safely provide dental care; and
2. under the age of 5; or
3. severely disabled; or
4. has a medical condition and requires admission to a Hospital or outpatient surgery facility and general anesthesia for dental care treatment.

We may require prior authorization for general anesthesia and hospitalization or surgical facility charges for dental procedures in the same manner that prior authorization is required for other covered benefits.

Diabetes Coverage Benefit

Benefits are payable for Medically Necessary equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy for Covered Persons with insulin-dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin-using diabetes as prescribed by a Physician. Diabetes in-person outpatient self-management training and education must be provided by a certified, registered or licensed health care professional.

Benefits are payable at the same level as any other Sickness.

Hemophilia and Congenital Bleeding Disorders Benefit

Benefits will be provided at the same level as any other Sickness for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Covered benefit includes the purchase of blood products and Blood Infusion Equipment required for home treatment of routine bleeding episodes when the Home Treatment Program is under the supervision of the State-Approved Hemophilia Treatment Center.

Blood Infusion Equipment includes, but is not limited to, syringes and needles.

Blood Product includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

Hemophilia means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles.

Home Treatment Program means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.

State-Approved Hemophilia Treatment Center means a Hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with Hemophilia and other congenital bleeding disorders.

Hysterectomy Benefit

Benefits will be payable for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy. Benefit will include a

minimum stay in the Hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy.

Benefits will be paid at the same level as any other inpatient Sickness.

Hospice Care Benefit

Benefits will be provided at the same level as any other Sickness for Hospice Services.

Hospice Services mean a coordinated program of home and inpatient care provided directly or under the direction of a licensed hospice and shall include Palliative Care and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.

Individuals With a Terminal Illness means individuals whose condition has been diagnosed as terminal by a licensed Physician, whose medical prognosis is death within six months, and who elect to receive Palliative Care rather than curative care.

Palliative Care means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

Lymphedema Benefit

Benefits will be provided at the same level as any other Sickness for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, as prescribed by a Physician.

Mammography Benefit

Benefits will be provided for low dose Mammography at the same level as any other Sickness for determining the presence of occult breast cancer. The following frequency:

- a) One screening mammogram to a Covered Person 35 through 39 years of age;
- b) One screening mammogram every two years for any Covered Person 40 through 49 years of age;
- c) One screening mammogram every year for any Covered Person 50 years of age or older.

Mammogram means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression

device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

Mastectomy Length of Stay Benefit

Benefits will be payable for inpatient care following a Mastectomy provided for 48 hours following radical or modified radical mastectomy and 24 hours following a total or partial Mastectomy with lymph node dissection for the treatment of breast cancer.

Benefits will be paid at the same level as any other inpatient Sickness.

Mastectomy Reconstruction Benefit

Benefits will be provided at the same level as any other Sickness for prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for a Covered Person incident to Mastectomy. Reconstructive Breast Surgery shall also include coverage for prostheses, determined as necessary in consultation with the attending Physician and patient, and physical complications of Mastectomy, including Medically Necessary treatment of lymphedemas.

Mastectomy means the surgical removal of all or part of the breast.

Reconstructive Breast Surgery means surgery performed (i) coincident with or following a Mastectomy or (ii) following a Mastectomy to re-establish symmetry between the two breasts.

Mental Health and Substance Abuse Benefit

Benefits will be provided at the same level as any other Sickness for Covered Persons for inpatient and partial hospitalization mental health and Substance Abuse Services on the following basis:

1. treatment of an adult as an inpatient at a Hospital, inpatient unit of a Mental Health Treatment Center, Alcohol or Drug Rehabilitation Facility or Intermediate Care Facility for a minimum period of 20 days per policy year.
2. treatment of a Child or Adolescent as an inpatient at a Hospital, inpatient unit of a Mental Health Treatment Center, Alcohol or Drug Rehabilitation Facility or Intermediate Care Facility for a minimum of 25 days per policy year;
3. up to 10 days of inpatient benefit described in (1) and (2) may be converted when Medically Necessary at the option of the Covered Person or parent of a Child or Adolescent receiving such treatment to a Partial

Hospitalization. The Benefit shall be no less favorable than an exchange of 1.5 days of Partial Hospitalization coverage for each inpatient day of coverage and includes:

- (a) A maximum of 20 visits for Outpatient Treatment of an Adult, Child or Adolescent per each policy year;
- (b) Benefits are subject to the same Deductible and co-payment as any other Sickness covered under this Policy and limits shall be no more restrictive than the limits of benefits applicable to any other Sickness.

Benefits will be provided at the same level as any other Sickness for Covered Persons for outpatient mental health and Substance Abuse Services on the following basis:

1. A maximum of 20 visits for Outpatient Treatment of an Adult, Child or Adolescent per each policy year.

If all covered expenses for an outpatient Mental Health or Substance Abuse treatment visit apply toward any required deductible of the Policy, then such visit will not count toward the outpatient visit benefit maximum set forth in the Policy.

Definitions:

Adult means any person who is nineteen years of age or older.

Alcohol or Drug Rehabilitation Facility means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health, or by the Department of Behavioral Health and Developmental Services or (ii) a state agency or institution.

Child or Adolescent means any person under the age of nineteen years.

Inpatient Treatment means mental health or Substance Abuse Services delivered on a twenty-four-hour per day basis in a Hospital, Alcohol or Drug Rehabilitation Facility, an Intermediate Care Facility or an inpatient unit of a Mental Health Treatment Center.

Intermediate Care Facility means a licensed, residential public or private facility that is not a Hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour per day, state-approved program of inpatient Substance Abuse Services.

Medication Management Visit means a visit no more than twenty minutes in length with a licensed Physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

Medication Management Visits will be covered the same as medication management visits for the treatment of any other Sickness. Such visits will not be counted as outpatient visits in the calculation of the benefit set forth under this section.

Mental Health Services means treatment for mental, emotional or nervous disorders.

Mental Health Treatment Center means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a Physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a Hospital under a contractual agreement with an established system for patient referral.

Outpatient Treatment means mental health or Substance Abuse Treatment Services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a Partial Hospitalization or intensive outpatient program.

Partial Hospitalization means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Substance Abuse Services means treatment for alcohol or other drug dependence.

Treatment means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychother-

apy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a Hospital, Alcohol or Drug Rehabilitation Facility, Intermediate Care Facility, Mental Health Treatment Center, a Physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope of practice set forth in s 54.1-3507.1 or s 54.1-3507.2, respectively, employed by a facility or program licensed to provide such treatment.

Pregnancy from Rape or Incest Benefit

Benefits will be provided at the same level as any other Sickness for pregnancy that resulted from an act of rape of a Covered Person provided the police were notified within 7 days following the occurrence. The 7-day notification requirement will be extended to 180 days in the case of an act of rape or incest of a female Covered Person under 13 years of age.

Prostate Cancer Screening Benefit

Benefits will be payable for one annual PSA prostate cancer screening test and digital rectal examinations for any male covered under this Policy who is 40 years of age or older and at high risk for prostate cancer or for covered males who are age 50 and over. Prostate cancer screening tests must be performed according to the most recent published guidelines of the American Cancer Society.

Telemedicine Services Coverage

Benefits shall be provided for the cost of healthcare services provided through Telemedicine Services. We shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the Covered Person delivered through Telemedicine Services on the same basis as coverage for the provision of the same service through face-to-face consultation or contact.

As used in this section, "telemedicine services," as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. "Telemedicine Services" do not include an audio-only telephone, electronic mail message, or facsimile transmission.

Exclusion:

The following exclusion is in addition to any exclusion found in the Policy:

Reimbursement will not be made to the treating provider or the consulting provider for technical fees or costs for the provision of Telemedicine Services.

Benefits shall be subject to the Deductibles, Co-payment and Coinsurance requirements that are applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

Bone Marrow Transplant Benefit

Benefit will be provided for treatment of breast cancer by dose-intensive chemotherapy/ autologous bone marrow transplants or stem cell transplants when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college.

Benefits are subject to the same deductible and co-payment as any other coverage under this Policy.

Morbid Obesity Treatment Benefit

Benefits will be provided for the treatment of Morbid Obesity through gastric bypass surgery or other methods as recognized by the National Institutes of Health as effective for the long term reversal of Morbid Obesity.

Morbid Obesity means (1) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables (2) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or (3) a BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.

Obstetrical and Postpartum Benefit

Benefits will be provided for inpatient obstetrical treatment in a Hospital. The reimbursement for obstetrical services by a Physician shall be based on the charges for the services determined according to the same formula by which the charges are developed for other medical and surgical procedures.

Benefits will be subject to the same Deductible and co-payment as any other Sickness under this Policy.

Postpartum Benefit

If benefits are provided for obstetrical services, benefits will be provided for inpatient care and a home visit or visits in accordance with medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists.

Prosthetic Device Benefit

Benefit shall be provided for Medically Necessary prosthetic devices, their repair, fitting, replacement, and components, as follows:

1. As used in this section:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

2. Prosthetic device coverage does not include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not include prosthetic devices designed primarily for an athletic purpose.

Child Health Supervision Services Benefit

If dependent coverage is provided, benefits will be provided for dependent children for: the periodic review of a child's physical and emotional status by or under the supervision of a doctor or Physician.

Benefits are payable from the moment of birth through the age of six years at the following age intervals: birth; two (2) months; four (4) months; six (6) months; nine (9) months; twelve (12) months; fifteen (15) months, eighteen (18) months; two (2) years; three (3) years; four (4) years; five (5) years; and six (6) years.

Services rendered during a periodic review will only be covered to the extent that services are provided by or under the supervision of a single Physician during the course of one visit.

Periodic review includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests. The above payments are exempt from Deductible, Coinsurance, co-payments, limitations and other Policy limitations.

Cleft Lip and/or Cleft Palate Benefit

If dependent coverage is provided, newborn children born with cleft lip and/or cleft palate, will receive coverage for services for the care and treatment of such cleft lip and/or cleft palate. Treatment shall include to the extent Medically Necessary: oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; Medically Necessary orthodontic treatment; Medically Necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment. Any condition or illness which is related to or developed as a result of the cleft lip or cleft palate shall be considered to be compensable for coverage under this benefit.

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

Early Intervention Benefit

If dependent coverage is provided, benefits will be provided up to a limit of \$5,000 per insured per Policy or calendar year for Medically Necessary early intervention services provided to a Covered Person.

Benefits will be subject to the same Deductible and co-payment as any other Sickness under this Policy.

Early Intervention Services means Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of the Department of Behavioral Health and Developmental Services as eligible for services.

Medically Necessary early intervention services for the population certified by the Department of Mental Health, the Department of Behavioral Health and Developmental Services means those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

Infant Hearing Screening Test Benefit

If dependent coverage is provided, benefits will be provided for infant hearing screenings and all necessary audiological examinations for newborn children using any technology approved by the USFDA and as recommended by the national Joint Committee on Infant Hearing. Coverage will include follow-up audiological examinations as recommended by a Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

Benefits will be paid at the same level as any other inpatient Sickness.

Newborn Immunization Benefit

If dependent coverage is provided, benefits will be provided for the Usual and Customary Charges incurred for all immunizations administered to each newborn child from birth to 36 months of age. This includes immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other such immunizations as may be prescribed by the Commissioner of Health.

STUDENT HEALTH SERVICES

The Insured must use the resources of the University's Student Health Services when first seeking medical treatment. Treatment will be either administered at the Student Health Services or a referral to another facility will be given. Expenses incurred for medical treatment received outside of the Student Health Services without prior approval or referral will be paid as shown on the Schedule of Benefits. The written referral issued by the Student Health Services must accompany the written notice of the claim when it is submitted.

Student Health Services referral will not be required under the following conditions:

- (1) a Medical Emergency. The student must return to Student Health Services for any needed follow-up care;
- (2) when Student Health Services is closed;
- (3) when service is rendered at another facility during school break or vacation periods;
- (4) when Necessary Medical service is received and the Insured is more than 100 miles from the campus;
- (5) when Necessary Medical care is obtained and the Insured is no longer able to use Student Health Services due to a change in student status;
- (6) maternity care;
- (7) psychiatric care;
- (8) services not offered by Student Health Services.

CLAIM PROCEDURES

1. Pick up a claim form from the Business Office, or contact the Plan Administrator (see below).
2. The claim form must be completed and signed. Written proofs of loss (itemized bills) must be furnished with the claim within 90 days from the date of loss. Mail the claim to the address on the form.
3. Preauthorization and precertification of the benefits to providers of medical service are not required nor provided by us.
4. Questions concerning claim procedures should be referred to the Plan Administrator. Claim forms are available on our web site:
www.BollingerColleges.com/EMU

**SUBMIT ALL CLAIMS OR INQUIRES TO THE
PLAN ADMINISTRATOR**



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

LOCAL BROKER:
BB&T Insurance Services
P.O. Box 929Harrisonburg, VA 22801
1-800-296-1301 or (540) 437-1300
Fax: (504) 437-0435
Email: pfurr@BBandT.com

Information regarding the Monumental Life procedures for filing an inquiry, grievance or appeal can be obtained at: www.BollingerColleges.com/EMU. A paper copy of this information is available upon request.

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance at:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157 • Richmond, VA 23218
Toll-free: 1-877-310-6560 Local: 804-371-9032
Fax: 804-371-9944 Email: Ombudsman@scc.virginia.gov

Internet: Information regarding the Ombudsman may be found by accessing the State Corporation Commission's web page at: <http://www.scc.virginia.gov/boi>

PREFERRED PROVIDER NETWORK:



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

This brochure is based on Policy #CVA209H
Policy Form SH1000GPM(Rev.2000).VA

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