

2012-2013 Student Injury and Sickness Insurance Plan

LINCOLN UNIVERSITY

Your student health insurance coverage, offered by Monumental Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are \$100,000 for policy years beginning on or after July 1, 2012, but before September 23, 2012, \$500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage has a \$50,000.00 per Injury or Sickness maximum benefit with internal limits thereunder. If you have any questions or concerns about this notice, contact Bollinger Inc., Short Hills, NJ, 1-866-267-0092. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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

Offered and Administered by:
Bollinger, Inc.

Underwritten by:
Monumental Life Insurance Company
Cedar Rapids, Iowa
a Transamerica company

Policy Number: CMO111I

THE LINCOLN UNIVERSITY STUDENT HEALTH INSURANCE PLAN

The Lincoln University Student Health Insurance Plan has been developed especially for Lincoln University students. The Plan provides coverage for Sickness and Injuries that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. Lincoln University is pleased to offer the Plan as described in this brochure.

WHERE TO FIND HELP

For questions about:

- Insurance Benefits
- Claims Processing

Please contact:

Bollinger, Inc.

P.O. Box 727

Short Hills, NJ 07078-0727

(866) 267-0092

www.BollingerColleges.com/LincolnUniversity

For Preferred Provider Listings:

Please contact:

Bollinger, Inc.

or use the Internet at:

www.BollingerColleges.com/LincolnUniversity

For questions about:

- Enrollment Forms
- Health Services

Please contact:

Lincoln University

Thompkins Health Center

(573) 681-5476

For questions about:

On Call International 24/7 Emergency Travel Assistance Services

Please contact:

On Call International

US & Canada: 866-525-1955

International Collect: 603-328-1955

POLICY PERIOD

1. Annual Term Students: Coverage for all Insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on **June 30, 2012**, and will terminate at 12:00 a.m. on **August 15, 2013**.

2. New Spring Semester Students: Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a.m. on **January 21, 2013**, and will terminate at 12:00 a.m. on **August 15, 2013**.

3. Insured Dependents: Coverage will become effective on the same date the Insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. Examples include, but are not limited to, the date the Insured student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

PREMIUM RATES

The following rates include an administrative fee:

	Annual	Fall	Spring/Summer	Summer
Student	\$495	\$247.50	\$247.50	\$104
Spouse	\$1,045	\$440	\$605	\$240
Child(ren)	\$1,045	\$440	\$605	\$240

DEDUCTIBLES

The following Deductibles are applied before Covered Medical Expenses are payable:

Student: \$25 per condition per Policy Year. (waived with Student Health Services Referral)

Spouse: \$25 per condition per Policy Year.

Child: \$25 per condition per Policy Year.

LINCOLN UNIVERSITY STUDENT Injury and Sickness Insurance Plan

This is a brief description of the Injury and Sickness Medical Expense benefits available for Lincoln University students and their eligible dependents. The Plan is underwritten by Monumental Life Insurance Company. The exact provisions governing this insurance are contained in the Master Policy. See the University for additional information. The Plan is administered by Bollinger, Inc., P.O. Box 727, Short Hills, NJ 07078-0727.

STUDENT COVERAGE

Eligibility

Registered Students taking 12 credits or more:

All other registered students taking 12 or more credit hours are eligible and must be enrolled in the plan unless proof of comparable coverage is provided.

Registered Students taking less than 12 credits and Dependents:

All other registered students taking less than 12 credit hours are eligible and may participate in the plan on a voluntary basis.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment

International Students:

International students taking credit hours are automatically enrolled in the plan.

Registered Students taking 12 credits or more:

Registered students taking 12 credit hours or more are automatically enrolled in the plan unless proof of comparable coverage is provided by the waiver deadline. To make your insurance selection on line visit www.BollingerColleges.com/LincolnUniversity.

Registered Students taking less than 12 credits and Dependents:

Students taking less than 12 credit hours and eligible dependents are eligible to enroll in the Student Health Insurance Plan on a voluntary basis by the enrollment deadlines listed below. To enroll on line visit www.BollingerColleges.com/LincolnUniversity.

Note: Payment is due to Bollinger at the time of enrollment and will not be billed to the University Student Account.

WAIVER PROCESS/PROCEDURE

Eligible students will automatically be enrolled in this plan, unless a completed Waiver Form has been received by Lincoln University by the specified deadline dates listed below:

Waiver and Enrollment Deadline Date	
Fall	8/31/12
Spring/Summer	1/18/13

Waiver submissions may be audited by Lincoln University, Bollinger Inc. and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school's waiver requirements.

PREMIUM REFUND POLICY

Except for medical withdrawal due to a covered Injury or Sickness, any Insured student who did not enroll in school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Insured students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid. **No refund will be allowed.**

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

DEPENDENT COVERAGE

Eligibility

Insured students may also enroll their lawful spouse and dependent children up to age 26 who reside with and are fully supported by, the Insured student for the same coverage.

Enrollment

Dependents are eligible to enroll in the Student Health Insurance Plan on a voluntary basis by the enrollment deadline listed below. To enroll on line visit www.BollingerColleges.com/LincolnUniversity. The Fall enrollment deadline is **August 31, 2012**. Dependent enrollment applications will not be accepted after **August 31, 2012**, unless there is a significant life change, that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage, under another health plan.) The Spring enrollment deadline is **January 21, 2013**.

Newborn Infant Coverage, Adopted Child Coverage, and Children Who Must Be Covered Due to A Qualified Child Support Order

A child born to a Covered Person shall be covered for Injury, Sickness, and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the Lincoln University Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional premium starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Person for 31 days from the moment of placement, provided the child lives in the household of the Covered Person and is dependent upon the Covered Person for support. To extend coverage for an adopted child past the 31 days, the Covered Person must (1) enroll the child within 31 days of placement of such child, and (2) pay any additional premium, if necessary, starting from the date of placement. A dependent will not be considered a late enrollee if a court order requires the Covered Person to provide coverage for his or her eligible dependent. Such coverage will become effective on the date of the court order and will remain in effect for 31 days. To extend coverage past the 31 days, the Covered Person must (1) enroll the child(ren) within 31 days of the court order, and (2) pay any additional premium, if necessary, starting from the date of the court order.

Please note: Previously Covered Persons must re-enroll for dependent coverage by August 31, 2012 for the Fall Semester, and by January 21, 2013 for the Spring Semester, in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, a condition existing during such a break which is a Pre-Existing Condition will not be payable. See Continuously Insured Section of this Brochure.

CONTINUOUS COVERAGE

Covered Persons who have maintained Continuous Coverage under the Policy and prior student health insurance policies issued to the school will be covered for any Pre-Existing Condition that manifests itself while continuously insured, except for expenses payable under prior policies in the absence of the Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by August 31, 2012 for Fall Semester, and by January 21, 2013, for the Spring Semester in order to avoid a break in coverage for conditions that existed in the prior Policy Year. Once a break in Continuous Coverage occurs, the definition of Pre-Existing Conditions will apply.

PREFERRED PROVIDER NETWORK

Bollinger, Inc. has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the Lincoln University campus.

The Lincoln University Student Health Insurance Plan for the 2012-2013 Policy Year has a Preferred Provider Organization network. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of Lincoln University, Bollinger, Inc., or Monumental Life Insurance Company. A complete listing of Preferred Providers is available online by contacting Bollinger, Inc. at www.BollingerColleges.com/LincolnUniversity.

REFERRAL REQUIREMENTS

The Insured Student should use resources of the 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.

A \$25 per condition outpatient Annual Deductible will be waived for students who initiate care at Student Health Services. Dependents are not eligible to use the Student Health Center and therefore will be responsible for the \$25 per condition outpatient Annual Deductible.

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

- (1) Medical Emergency. The student must return to the 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 50 miles from the campus;
- (5) when Necessary Medical care is obtained and the Insured is no longer able to use the Student Health Services due to a change in student status;
- (6) maternity care;
- (7) Psychiatric Care;
- (8) services not offered by the Student Health Services.

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 180 days immediately prior to his Effective Date of Coverage under this Policy.

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

- (1) 180 consecutive days 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 this Policy and the school's prior policies for two continuous years; or
- (3) The Insured has been receiving benefits under the school's prior policies and has been continuously insured since the date of accident, Injury, or Sickness, whichever occurs first.

CREDIT FOR PRIOR COVERAGE

This Policy provides portability of coverage as it relates to "Pre-existing Conditions". The Pre-existing Condition limitation set forth in this 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. Any Pre-existing Condition limitation is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the Insured Person as of the enrollment date, for similar services covered under this Policy and the prior coverage.

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

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

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

CREDIT FOR TIME COVERED

If the Insured Person was insured under a prior plan that this plan replaces and replacement is effective within sixty-three days of the termination date of the prior plan, then credit will be given for each day of coverage under the prior plan towards satisfaction of the 180 day limitation on Pre-existing Conditions. Credit will be given only for those benefits for which the prior plan contained which are also contained in this Policy.

DESCRIPTION OF BENEFITS

To maximize your savings and reduce out-of-pocket expense, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Providers are subject to Usual and Customary Charge (U&C) maximums. Any charges in excess of the U&C are not covered under the Plan. The payment of any applicable Deductibles, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person.

This plan will never pay more than \$50,000 per person, per condition, per policy year. Covered Medical

Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Injury which occurs during the Policy Year are payable up to a \$500 Policy Year Maximum. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

SUMMARY OF BENEFITS

DEDUCTIBLES

The following Deductibles are applied before Covered Medical Expenses are payable:

Student: \$25 per condition per Policy Year. (waived with a Student Health Services Referral).

Spouse: \$25 per condition per Policy Year.

Child: \$25 per condition per Policy Year.

COINSURANCE

Covered Medical Expenses are payable at the coinsurance percentage specified in the schedule, after any applicable deductible, up to a maximum benefit of \$50,000 per person, per condition, per Policy Year.

Unless otherwise specified, all coverage is based on:

Preferred Care: 100% of the Negotiated Charge up to \$10,000, then 80% up to the overall maximum of \$50,000.

Non-Preferred Care: 100% of the Usual and Customary Charge up to \$10,000, then 80% up to the overall maximum of \$50,000 - subject to the following schedule.

Hospital Room and Board Expense Benefits are limited to \$850 per day.

Intensive Care Unit Expense Benefits are limited to \$850 per day.

Miscellaneous Hospital Expense Covered Medical Expenses include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.
Benefits are limited to \$850 per day.

Physician Hospital Visit/
Consultation Expenses Covered Medical Expenses for charges for the non-surgical services of the attending Physician, or a consulting Physician.
Benefits are limited to \$50 per day. Not applicable when related to surgery.

Surgical Benefits (Inpatient and Outpatient) Surgical Expense - \$6,000 maximum per Injury or Sickness per policy year (for both inpatient and outpatient)

Surgical Expense Covered Medical Expenses for charges for surgical services, performed by a Physician.
Benefits are limited to the \$6000 per Injury or Sickness, per Policy Year.

Anesthetist and
Assistant Surgeon Expense

Covered Medical Expenses for the charges of an anesthetist and assistant surgeon, during a surgical procedure.

Benefits are limited to \$625 per Injury or Sickness, per Policy Year.

Ambulatory Surgical Expense

Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center.

Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.

Subject to the Outpatient \$2,000 per condition, per Policy Year maximum.

Outpatient Benefits - Covered Medical Expenses are payable up to a combined maximum of \$2000 per Injury or Sickness per Policy Year. Covered Medical Expenses include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.

Hospital Outpatient Department
or Walk-in Clinic Visit Expense

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Emergency Room Expense

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Please note: this per visit Co-pay does not apply towards meeting the annual Deductible.

Urgent Care Expense

Benefits include charges for treatment by an urgent care provider.

Please note: A covered person should not seek medical care or treatment from an urgent care provider if their Sickness, Injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.

Urgent Care

Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.

The covered person should contact their primary care physician after medical care is provided to treat an urgent condition.

Non-Urgent Care

Covered Medical Expenses for charges made by an urgent care provider to treat a *non-urgent condition* are payable as follows:

No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.

Non-urgent care includes, but is not limited to, the following:

- Routine or preventive care (this includes immunizations),
- Follow-up care,
- Physical therapy,
- Elective surgical procedures, and
- Any lab and radiologic exams which are not related to the treatment of the urgent condition.

A separate preferred urgent care Co-pay/deductible applies to each visit for urgent care by a covered person to a preferred urgent care provider. This does not apply if the covered person is admitted to a hospital as an inpatient right after a visit to an urgent care provider.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Ambulance Expense

Covered Medical Expenses are payable to a maximum of \$500 per trip for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.

Pre-Admission Testing Expense

Subject to the outpatient \$2000 per condition, per Policy Year.

Physician's Office Visits

\$50 per visit Co-pay
Benefits are limited to \$50 per visit subject to the outpatient \$2000 per condition, per Policy Year maximum.

Laboratory and X-Ray Expense

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

High Cost Procedures Expense

“High Cost Procedure” means any outpatient procedure costing over \$200.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Therapy Expense

Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:

- Physical Therapy,
- Chiropractic Care,
- Speech Therapy,
- Inhalation Therapy, or
- Occupational Therapy.

Expenses for Chiropractic Care are Covered Medical Expenses, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function. Covered Medical Expenses for Chiropractic Care include initial diagnosis and clinically appropriate and medically necessary services and supplies required to treat the diagnosed disorder.

Expenses for Speech and Occupational Therapies are Covered Medical Expenses only if such therapies are a result of Injury or Sickness.

Physical therapy must be for rehabilitation only after a surgery. All other therapy must be initiated within 6 months of the onset of symptoms. All therapy must be provided by a therapist who is licensed in accordance with state law, and practicing within the scope of their license. All therapy must be completed within 60 days of the date that it starts.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Chemotherapy Expense

Covered Medical Expenses for chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. Covered medical expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Routine Patient Care
(pursuant to a Qualified
and Clinical Trial)

Covered Medical Expenses include routine patient care costs incurred as the result of phase II, III, or IV of a clinical trial is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Benefits will include routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for Usual & Customary and Medically Necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

Bone Marrow Antigen Testing	<p>“Routine patient care costs” will include coverage for Usual & Customary and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:</p> <ul style="list-style-type: none"> (a) The investigational item or service itself, (b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, and (c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial. <p>Subject to the outpatient \$2000 per condition, per Policy Year maximum.</p>
Durable Medical	<p>Covered Medical Expenses include charges for the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation.</p> <p>Subject to the outpatient \$2000 per condition, per Policy Year maximum.</p>
Prosthetic Devices Expense	<p>Subject to the outpatient \$2000 per condition, per Policy Year maximum.</p> <p>Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an Injury or Sickness.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p>Payable as any other Sickness.</p>
Outpatient Physical Therapy Expense	<p>Covered Medical Expenses for physical therapy are payable as follows when provided by a licensed physical therapist and only when physical therapy begins within 6 months of the onset of symptoms.</p> <p>Subject to the outpatient \$2000 per condition, per Policy Year maximum.</p>
Dental Injury Expense	<p>Covered Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> • Natural teeth damaged, lost, or removed, or

• Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan.

Any such teeth must have been:

- Free from decay, or
- In good repair, and
- Firmly attached to the jawbone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If:

- Crowns (caps), or
- Dentures (false teeth), or
- Bridgework, or
- In-mouth appliances, are installed due to such injury, Covered Medical Expenses include only charges for:
 - The first denture or fixed bridgework to replace lost teeth,
 - The first crown needed to repair each damaged tooth, and
 - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.

Benefits are limited to \$200 maximum, per Policy Year.

Anesthesia and Hospital Charges for Dental Care

Covered Medical Expenses include charges incurred by a covered person for the administration of general anesthesia and hospital charges for dental care only to the following covered persons:

- (i) A child under the age of 5,
- (ii) A person who is severely disabled, or
- (iii) A person who has a medical or behavioral condition which required hospitalization or general anesthesia when dental care is provided.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Diagnostic Testing for Attention Disorders and Learning Disabilities Expense

Covered Medical Expenses for diagnostic testing for:

- Attention deficit disorder, or
 - Attention deficit hyperactive disorder, or
 - Dyslexia.
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Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Policy.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Early Intervention Services

Covered Medical Expenses include early intervention services for children from birth to age three. "Early intervention services" means:

- Medically necessary speech and language therapy,
- Occupational therapy,
- Physical therapy, and
- Assistive technology devices.

Such coverage shall be limited to \$3,000 for each covered child per Policy Year, with a maximum of \$9,000 per child.

No payment made for specified early intervention services shall be applied against any maximum lifetime aggregate specified in the policy.

Child Health Supervision Services Expenses

Covered Medical Expenses include Child Health Supervision Services for a dependent child from birth to age 13. Expenses are the charges for Child Health Supervision Services.

Covered Medical Expenses will only include charges of one physician for Child Health Supervision Services performed at birth and at approximately each of the following ages:

2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, and 12 years.

Not covered are charges incurred for:

- Services which are covered to any extent under any other part of this Plan,
- Services which are for diagnosis or treatment of a suspected or identified injury or disease,
- Services not performed by a physician or under his or her direct supervision,
- Medicines, drugs, appliances, equipment, or supplies, or
- Dental exams.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Child Immunizations

Covered Medical Expenses include coverage for dependent children from birth to five years of age for the following:

• Charges made by a physician for materials and the administration the following immunizations given to covered dependent children from birth to age 5:

- Diphtheria,
- Haemophilus influenza type B,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Poliomyelitis,
- Rubella,
- Rubeola,
- Tetanus, and
- Varicella.

In addition, immunizations recognized by the Advisory Committee on Immunization Practices (ACIP) will also be included as Covered Medical Expenses. Not included are charges made by a physician for an office visit for such administration. This coverage is not be subject to any Co-pay/deductible.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Well Baby Care Expense

Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.

Routine preventive and primary care services are services rendered to a covered dependent child, from the date of birth through the attainment of nineteen (19) years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, and developmental assessments.

Appropriate and necessary immunizations from birth to age 5, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

Covered Medical Expenses for a newborn covered dependent includes these newborn services: hearing screening, necessary rescreening, audiological assessment and follow-up and initial amplification.

Coverage for such services shall be provided only to the extent that such services are provided by, or under the supervision of a physician, or other licensed professional.

Consultant or
Specialist Expense

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Covered Medical Expenses include coverage for a second opinion rendered by a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician.

For consultant expenses benefits are limited to \$150 per visit, subject to the outpatient \$2000 per condition, per Policy Year maximum.

Mental Health Benefits

Mental and Nervous
Disorders Inpatient Expense

Covered Medical Expenses for the diagnosis and treatment of Mental and Nervous Disorders are payable on the same basis as any other Sickness.

A referral is not required for this benefit.

Benefits are limited to \$850 per day.

Mental and Nervous
Disorders Outpatient Expense

Covered Medical Expenses for the diagnosis and treatment of Mental and Nervous Disorders are payable on the same basis as any other Sickness.

A referral is not required for this benefit.

Benefits are limited to \$50 per visit subject to the outpatient \$2000 per condition, per Policy Year maximum.

Substance Abuse Benefits

Inpatient Expense

Covered Medical Expenses include expenses incurred by a covered person during partial hospitalization or while the covered person is confined as a full-time inpatient in a facility established primarily for the treatment of alcohol and drug addiction.

A referral is not required for this benefit.

Benefits are limited to \$850 per day.

The inpatient maximum days are 90 days per Policy Year.

Outpatient Expense

Covered Medical Expenses include charges for treatment of alcohol and drug addiction while the covered person is not confined as a full-time inpatient in a hospital.

A referral is not required for this benefit.

Benefits for the treatment of alcoholism and drug addiction will be payable on the same terms applicable to the treatment of any other disease, subject to the following limitations:

- 26 days of outpatient treatment per Policy Year through a non-residential treatment program licensed by the Department of Mental Health,
- 21 days of treatment per Policy Year through a residential treatment program licensed by the Department of Mental Health,
- 6 days of detoxification treatment per Policy Year.

Benefits are limited to \$50 per visit up to the Outpatient maximum, subject to the outpatient \$2000 per condition, per Policy Year maximum.

Partial hospitalization, inpatient, and outpatient benefits for Treatment Of Mental And Nervous Disorders require pre-certification.

Maternity Benefits

Maternity Expense

Covered Medical Expenses include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours following an uncomplicated cesarean section for the mother and her newly born child.

Any decision to shorten such minimum coverages shall be made by the attending physician, in consultation with the mother. In such cases, covered services may include: two post-delivery visits by a health care provider either at the mother's home, a health care provider's office or a health care facility for purposes of post discharge care including: parent education, and assistance and training in breast or bottle-feeding. For the purposes of this provision, "health care provider" would include the covered person's physician or other provider qualified to provide post discharge care and acting within the scope of his or her license.

Complications of pregnancy, including spontaneous and non-elective abortions, are considered a Sickness, and are covered under this benefit. Voluntary or elective abortions are not covered.

Coverage for testing for lead poisoning for pregnant women will be covered same as any other expense.

Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness.

A referral is not required for this benefit.

Well Newborn
Nursery Care Expense

Benefits include charges for routine care of a covered person's newborn child as follows:

- Hospital charges for routine nursery care during the mother's confinement, but for not more than four days [for a normal delivery],
- Physician's charges for circumcision, and
- Physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day.

Additional Benefits

Prescription Drug Benefit

Prescription Drug Benefits are payable as follows:
Preferred Care Pharmacy: Following a \$20 Co-pay for each Brand Name Prescription Drug or 100% coverage for each Generic Prescription Drug 30 day supply.

Non-Preferred Care Pharmacy: Following a \$20 Co-pay for each Brand Name Prescription Drug or 100% coverage for each Generic Prescription Drug 30 day supply.

Covered Medical Expenses are payable up to a maximum of \$500 per Policy Year.

You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement.

This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Caremark ID card when obtaining your prescriptions.

Medications not covered by this benefit include, but are not limited to: allergy sera, inhalers, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.

For assistance or for a complete list of excluded medications, please contact Caremark at (800) 391-6443 (available 24 hours).

Caremark provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.Caremark.com

Diabetic Treatment,
Equipment and
and Supplies Expense

Covered Medical Expenses include all physician-prescribed medically appropriate and necessary treatment, equipment supplies used in the management and treatment of diabetes. Coverage shall include persons with gestational, type I or type II diabetes. Payable as any other Sickness.

Diabetic Self-Management
Training Expense

Covered Medical Expenses for diabetic self-management training are payable as follows: Payable as any other Sickness.

Osteoporosis
Screening Expense

Covered Medical Expenses include coverage for services related to diagnosis, treatment and appropriate management of osteoporosis for individuals with a condition or medical history for which bone mass measurement is medically indicated.

Subject to the outpatient \$2000 per condition, per Policy Year maximum.

Non Prescription
Enteral Formula Expense

Benefits include charges incurred by a covered person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by:

- Crohn's Disease,
- Ulcerative colitis,
- Gastroesophageal reflux,
- Gastrointestinal motility,
- Chronic intestinal pseudoobstruction, and
- Phenylketonuria or any inherited diseases of amino acids and organic acids.

Covered Medical Expenses for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.

Covered Medical Expenses are payable as follows: Payable as any other Sickness.

Prescription
Contraceptive Devices

Covered Medical Expenses include:

- Charges incurred for contraceptive drugs and devices that by law need a physician's prescription, and that have been approved by the FDA.
- Related outpatient contraceptive services such as:
 - Consultations,
 - Exams,
 - Procedures, and
 - Other medical services and supplies

Payable as any other Sickness.

Benefits are subject to the outpatient \$2000 per condition, per Policy Year maximum.

A referral is not required for this benefit.

Pap Smear Expense

Covered Medical Expenses include one annual routine pap smear screening and pelvic examination for women age 18 and older.

Benefits are subject to the outpatient \$2000 per condition, per Policy Year maximum.

Mammography Expense

A referral is not required for this benefit.

Covered Medical Expenses will be paid for Expenses incurred for the following:

- (1) A baseline mammogram for women between the ages of 35 to 40, and
- (2) A mammogram on an annual basis for women 40 years of age and older.
- (3) A mammogram for any women, upon the recommendation of a physician, where such woman, her mother or her sister has a prior history of breast cancer.

Benefits are payable as follows:

Benefits are subject to the outpatient \$2000 per condition, per Policy Year maximum.

A referral is not required for this benefit.

Mastectomy and Breast
Reconstruction Expense
Benefit

Coverage will be provided to a covered person who is receiving benefits for a necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- Reconstruction of the breast on which a mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses,
- Treatment of physical complications of all stages of mastectomy, including lymphedemas, and
- Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction.

This is subject to the approval of the attending physician.

If such individual changes his or her insurer, the federal Women's Health and Cancer Rights Act shall provide coverage to this purpose.

This coverage will be provided in consultation with the attending physician and the patient. It will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

This is a mandate offer: Plans shall offer coverage for treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplantation or stem cell transplant. The offer shall be in writing and must be accepted in writing by the group policyholder or contract holder. This treatment shall not be considered subject to any greater coinsurance or co-payment than applicable to other coverage, except the policy may contain a provision imposing a lifetime benefit maximum of not less than \$100,000, for dose-intensive chemotherapy and transplant. Nothing in this provision shall prohibit an entity from including all or part of such mandate as standard coverage.

Routine Colorectal Cancer
Screening Expense

Even though not incurred in connection with a Sickness or Injury, benefits include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:

- One fecal occult blood test every 12 months in a row
- A Sigmoidoscopy at age 50 and every 3 years thereafter
- One digital rectal exam every 12 months in a row
- A double contrast barium enema, once every 5 years
- A colonoscopy, once every 10 years
- Virtual colonoscopy
- Stool DNA.

Payable as any other Sickness.

Routine Prostate
Cancer Screening Expense

Covered Medical Expenses include charges incurred by a covered person for the screening of cancer as follows:

- For a male age 50 or over, one digital rectal exam and one prostate specific antigen test each Policy Year.

Payable as any other Sickness.

Surgical Second
Opinion Expense

Covered Medical Expenses will include a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation.

Benefits are subject to the outpatient \$2000 per condition, per Policy Year maximum.

Elective Surgical Second
Opinion Expense

Covered Medical Expenses will include a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation.

Benefits are subject to the outpatient \$2000 per condition, per Policy Year maximum.

Acupuncture in Lieu
Anesthesia Expense

Covered Medical Expenses include acupuncture therapy, of when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.

Dermatological Expense

Benefits are limited to \$625 per Injury or Sickness.
Covered Medical Expenses include charges for the diagnosis and treatment of skin disease excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.

Benefits are subject to the outpatient \$2000 per condition, per Policy Year maximum.

Covered Medical Expenses do not include treatment for acne, or cosmetic treatment and procedures.

Podiatric Expense

Covered Medical Expenses include charges for podiatric services, provided on an outpatient basis following an Injury.

Payable as any other Sickness.

Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not Covered Medical Expenses.

Transfusion or Dialysis
Blood Expense

Covered Medical Expenses include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.
Payable as any other Sickness.

Licensed Nurse Expense

Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.

Skilled Nursing Facility Expense

Covered Medical Expenses include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered:

- In lieu of confinement in a hospital as a full time inpatient, or
- Within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.

Rehabilitation Facility Expense

Covered Medical Expenses include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.

Newborn Hearing Screening

Covered Medical Expenses include these newborn services: hearing screening, necessary rescreening, audiological assessment and follow-up and initial amplification.
Coverage for such services shall be provided only to the extent that such services are provided by, or under the supervision of a physician certified as an otolaryngologist or otolo-

gist, or an audiologist who either:

- Is legally qualified in audiology, or
- Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements, and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Payable as any other Sickness.

Coverage for newborn hearing screening and any necessary rescreening and audiological assessment shall be provided to newborns eligible for medical assistance and the children's health program with payment for the newborn hearing screening required as set forth in statute.

Loss or Impairment of Speech or Hearing Expenses

Benefits will be paid for expenses incurred for the diagnosis or non-surgical treatment by a physician for loss or impairment of speech or hearing, but only if the charge is made for:

- Diagnostic services rendered to find out if and to what extent the person's ability to speak or hear is lost or impaired.
- Rehabilitative services rendered that are expected to restore or improve a person's ability to speak.

Not covered are charges for:

- Diagnostic or rehabilitative services rendered before the person becomes eligible for coverage or after termination of coverage.
- Hearing aids, hearing aid evaluation tests and hearing aid batteries.
- Hearing exams required as a condition of employment.
- Special education for a person whose ability to speak or hear is lost or impaired. This includes lessons in sign language.

Except as provided in this special provision, Expenses for treatment of diagnosis or non-surgical treatment by a physician for loss or impairment of speech or hearing are payable on the same basis as any other Sickness.

Payable as any other Sickness.

GENERAL PROVISIONS

State Mandated Benefits

The Plan will pay benefits for the following mandated benefits and any other applicable mandate in accordance with Missouri insurance laws: Mammography; Mastectomy and Breast Reconstruction; Immunizations for Children; Inherited Metabolic Disease; Newborn Hearing Screening; Dental Anesthesia; Chiropractic; Prostate Cancer Screening; Pap Smears; Colorectal Cancer Screenings; Second Opinion for Cancer Diagnostic; Human Leukocyte Antigen Testing; Coverage for Child Health Supervision Services; Mental Illness and Alcoholism; Maternity Inpatient Care; Scalp Hair Protheses; Clinical Trials-Routine Patient Cost; Newborn Coverage; OB/GYN; Osteoporosis; and Contraceptive Coverage.

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 in excess of 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.

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.

TERMINATION OF COVERAGE

The insurance of any Covered Person will immediately terminate on the earliest of:

- (1) the date to which the premium is paid;
- (2) the date this Policy expires as shown on the Schedule of Benefits, subject to the Extension of Benefits After Termination provision;
- (3) the date of entrance into the armed forces of any country, a pro-rata portion of the premium paid will be returned; or
- (4) the date the Covered Person no longer meets the conditions of eligibility for coverage; or
- (5) the date the Covered Person enrolls in Medicare; or
- (6) the date the Insured begins a leave of absence or withdraws from the school, a pro-rata portion of the premium paid will be returned.

Termination will be made without prejudice to any existing expense. Coverage for any Insured who leaves the school before the end of the semester will continue in force through the end of the period for which a premium was paid.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this Policy ceases on the termination date. However, if a Covered Person is Hospital Confined on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date, Covered Medical Expenses for such Injury or Sickness will continue to be paid until the completion of his Hospital Confinement as long as the condition continues for the duration of recovery but not to exceed 90 days from the expiration date.

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

EXCLUSIONS:

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

- (1). Services that are provided normally without charge by the University's Health Center, infirmary or Hospital; or by any person employed by the University;
 - (2). Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except as required for repair caused by a covered Injury;
 - (3). Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline. This exclusion does not apply to insured students while taking flight instructions for school credit;
 - (4). Declared or undeclared war, riot, civil disorder, civil commotion or acts of terrorism;
 - (5). Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law;
 - (6). 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
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- respect to such person;
- (7). Cosmetic surgery or other reconstructive procedures or services except as the result of Injury occurring while coverage is in effect as to the Covered Person;
 - (8). Committing or attempting to commit an assault or felony; or fighting, except in self defense;
 - (9). Organ transplants;
 - (10). Expenses for allergy testing, allergy injections, vials, and allergy serum;
 - (11). Treatment of temporomandibular joint dysfunction (TMJ) and associated myofacial pain;
 - (12). Services or supplies which are experimental or investigative in nature: including the treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice and any such items requiring federal or other governmental agency approval not received at the time services were rendered;
 - (13). Expenses incurred after the termination date except as provided under the Extension of Benefits;
 - (14). Expenses resulting from a motor vehicle accident for which benefits are payable from Other Valid Insurance;
 - (15). Treatment for breast reduction; deviated nasal septum, including submucous resection and/or other surgical correction thereof family planning; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; lesions; warts; obesity and any condition resulting therefrom (including hernia of any kind); inguinal hernia; skeletal irregularities of one or both jaws, including testing thereof; sleep disorders; tubal ligation; and vasectomy;
 - (16). Hospital admissions for the primary purpose of performing acupuncture and acupuncture service provided to inpatients and outpatients;
 - (17). Expenses incurred within the Covered Person's home country or country of regular domicile other than the United States;
 - (18). Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate, intramural, or club sport, contest or competition sponsored by the school, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant;
 - (19). 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;
 - (20). Elective Surgery or Elective Treatment;
 - (21). Expenses incurred for manipulation and massage;
 - (22). Expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to natural teeth;
 - (23). Treatments, procedures, facilities, equipment, drugs, devices, supplies or services that are experimental or investigative;
 - (24). Hearing tests to the extent that the benefits are or would have been provided under accompanying regulations governing the health of school children and the special education of handicapped children or comparable requirements established by federal law;

DEFINITIONS

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under this 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.

ACTUAL CHARGE means the fee charged by the Physician or Hospital for a Covered Service.

AGGREGATE MAXIMUM BENEFIT means benefits for any one Injury or Sickness per Policy Year which are payable throughout a period of Continuous Coverage. Benefits will terminate at the end of a period of Continuous Coverage, subject to an Aggregate Maximum Benefit of \$50,000 for any one Injury or Sickness per Policy Year as shown on the Schedule of Benefits.

ALCOHOLISM TREATMENT FACILITY means a residential or nonresidential facility certified by the Department of Mental Health for treatment of alcoholism.

COINSURANCE means the out-of-pocket expenses to be paid by the Insured as a percentage of the Covered Medical Expenses.

COMPLICATIONS OF PREGNANCY means conditions whose diagnoses are distinct from Pregnancy, but are adversely affected by Pregnancy or are caused by Pregnancy, such as:

- (1) acute nephritis;
- (2) nephrosis;
- (3) cardiac decompensation;
- (4) missed abortion;
- (5) non-elective cesarean section;
- (6) ectopic Pregnancy which is terminated;
- (7) spontaneous termination of Pregnancy which occurs during a period of gestation in which a viable birth is not possible;
- (8) pernicious vomiting;
- (9) pre-eclampsia;
- (10) similar medical and surgical conditions of comparable severity.

It does not include:

- (1) false labor;
- (2) occasional spotting;
- (3) Physician's prescribed rest;
- (4) morning Sickness; and
- (5) similar conditions associated with the management of a difficult Pregnancy not constituting a medically distinct Complication of Pregnancy.

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

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

COVERED PERSON means the Insured or a Dependent for whom an application has been received and the required premium has been paid.

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

DEPENDENT means the Insured's spouse, unless they are legally separated; the Insured's children up to age 26 or and children whose support is required by a court decree.

Children include natural children, stepchildren, and legally adopted children. Newborn children are covered from the moment of birth and from the moment of a signed placement with the adoptive parents for adopted children. They must be primarily dependent on the Insured for support and maintenance.

A spouse or child who is covered under this Policy as an Insured will not be eligible as a Dependent. If a husband and wife are both insured as Students, a child will be the Dependent of only one.

ELECTIVE SURGERY AND ELECTIVE TREATMENT 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 Elec-

tive Treatment do not include any procedures deemed a Medical Necessity. Elective Surgery does not mean a Cosmetic Procedure required to correct an Injury for which benefits are otherwise payable under this Policy.

Elective Surgery and Elective Treatment includes but is not limited to surgery and/or treatment for acne; acupuncture; allergy and allergy vials, including allergy testing; bio-feedback type services; breast implants; breast reduction circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Policy, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are otherwise payable under this Policy; deviated nasal septum, including submucous resection and/or other surgical correction; family planning; fertility tests; hair growth or removal; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind), except for the treatment of an underlying covered Sickness; premarital examinations; preventive medicines or vaccines, except where required for the treatment of a covered Injury; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing; smoking cessation; temporomandibular joint dysfunction (TMJ); tubal ligation; vasectomy; and weight loss or reduction.

HOSPITAL means an institution which meets all of the following requirements:

- (1) it must be operated according to law;
- (2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
- (3) it must provide diagnostic and surgical facilities supervised by Physicians;
- (4) Registered Nurses must be on 24 hour call or duty;
- (5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility. It is not a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

INTENSIVE CARE UNIT means a facility in a Hospital other than the patient's bedroom or an operating or a recovery room. It must be designated by the Hospital as a department providing the highest level of Intensive Care.

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. 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.

POLICY YEAR means the period of time starting with the Effective Date of this Policy through the Termination Date of this Policy as shown on the Schedule of Benefits. The Policy Year is agreed to by the Policyholder and the Company.

PREFERRED PROVIDER ORGANIZATION means a diversified group of medical providers who have entered into agreements with the plan administrator to provide medical benefits and services to the Covered Persons.

PRESCRIPTION DRUGS means any Medically Necessary drugs that, under the applicable state or federal law, may be dispensed only upon written prescription of a Physician; and injectable insulin.

USUAL AND CUSTOMARY CHARGE means those charges for necessary treatment and services that are Usual & Customary 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 and the FAIR Health schedule of fees valued at the 90th percentile.

SICKNESS means an illness, or disease 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.

SKILLED NURSING FACILITY means an institution which meets all of the following requirements:

- (1) it must be operated pursuant to law;
- (2) it must be primarily engaged in providing in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
- (3) Registered or Licensed Practical Nurses must supervise 24 hours a day;
- (4) a daily record for each patient must be maintained.

This definition does not include a:

- (1) rest home or similar facility;
- (2) home or facility for the aged;
- (3) home or facility for drug addicts or alcoholics;
- (4) home or facility for care or treatment of mental diseases or disorders; or
- (5) home or facility for custodial or educational care.

MEDICAL EVACUATION BENEFIT

Upon receipt of due proof that a Covered Person incurred expenses for Physician ordered emergency medical evacuation, including medically appropriate transportation and Medically Necessary care en route to the nearest suitable hospital or a facility operated pursuant to law for the care and treatment of ill or injured persons or to the Covered Person's home country, when the Covered Person is critically ill or Injured, and appropriate local care is not available, we will pay the actual charges incurred not to exceed \$50,000 subject to the prior approval of the Claims Administrator for the Policy and the attending Physician.

Payment of a benefit under the terms of this provision is in lieu of all benefits otherwise payable under the Policy and any Riders. Insurance for the Covered Person ends upon the evacuation.

REPATRIATION BENEFIT

Upon receipt of due proof of a Covered Person's death, we will pay the actual charges for the preparation and transportation of the body to his home country or country of regular domicile, subject to the approval of the Claims Administrator of the Policy. If applicable, such action will be in accordance with any international standards. The benefit payable is not to exceed \$50,000 and death must occur at least 100 miles away from the Covered Person's city of residence. Benefits provided by this provision are paid in addition to any other benefits payable under the Policy.

CLAIM PROCEDURE

Customer Service Representatives are available 8:00 a.m. to 5:00 p.m. (ET), Monday through Friday, for any questions (866) 267-0092.

1. It is the Covered Person's responsibility to initiate the claim in order to obtain reimbursement.
 2. Obtain a claim form from the Lincoln University Health Services or www.BollingerColleges.com/LincolnUniversity and complete as indicated.
 3. Only one claim form needs to be submitted for each Injury or Sickness.
 4. Bills must be submitted within 90 days from the date of treatment.
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5. When submitting a claim form, attach available itemized medical bills to the claim form. Subsequent medical bills should be mailed promptly to Bollinger, Inc.

PRESCRIPTION DRUG CLAIM PROCEDURE

When obtaining a covered Prescription, please present your Caremark Pharmacy ID card. If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms or for information about mail-order prescriptions or network pharmacies, please call Caremark Customer Care toll free at 1-800-391-6443. Note: Caremark is not connected with Monumental Life Insurance Company.

STUDENT ASSISTANCE PROGRAM (Administered by On Call International)

Nurse Helpline: On Call shall provide Students enrolled in this Plan 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 Students (based on symptoms reported and/or health care questions asked by or on behalf of Students). Nurses shall not diagnose a Student's ailments.

Travel Assistance Services: Each Insured Student and his/her enrolled Dependents are eligible for travel assistance services when traveling 100 miles or more away from their home and campus address. Travel Services are only available for medical claims that are covered under the College's Student Accident and Sickness Insurance Plan. Services provided include: Emergency Medical Transportation (Evacuation/Repatriation); Medical Monitoring; Medical, Dental, & Pharmacy Referrals; Deposit, Advance, & Payment Guarantees; Dispatch of Medicine, Physician, or Nurse; Return of Deceased Remains; Return of Minor Children Assistance; Pre-Trip Information; 24/7 Emergency Travel Arrangements; Translation Assistance; Emergency Travel Funds Assistance; Worldwide Legal Assistance; Lost/Stolen Travel Documents Assistance; Emergency Message Forwarding; and Lost Luggage Assistance.

Bedside Visit: In the event that a covered student will be hospitalized 7 days or longer, On Call International will provide a benefit of up to \$2,500 for a parent or family member to join the hospitalized student. The benefit can go towards transportation and accommodations. In all cases On Call International must make and pay for the travel and accommodations arrangements. There is no reimbursement for transportation or accommodations if made by the family or school.

Emergency Return Home: If a parent or sibling of a covered student dies or is hospitalized for a life threatening illness while the student is away at school (100 miles or more), On Call International will provide a benefit of up to \$2,500 for the student to return home. In all cases On Call International must make and pay for the travel arrangements. There is no reimbursement for transportation if made by the student, family or school.

Identity Theft Recovery Assistance: In the event that a covered student suspects he or she is a victim of identity theft, the student may contact On Call International to speak to the Identity Theft Recovery Unit. The Identity Theft Recovery Unit is a team of trained Fraud Specialists who will listen, document, and support participants who experience identity theft. The Fraud Specialist will: obtain participant's permission to pull and review their 3-bureau credit report in detail, with the participant; enroll the customer in six months of daily credit bureau monitoring to monitor and detect suspicious activity; document the event and contact history with participant; at participant request, assist in the placement of Fraud Alerts with major credit reporting agencies; write dispute letters on behalf of participant for signing and forwarding to National Credit Bureaus and Creditors. The Identity Theft Recovery Unit provides victims with a Fraud First Aid Kit which includes: Tips for Fraud Victims; Credit Bureau Reporting Agency Information; Contact History Tracking; Pre-populated letters to creditors to dispute suspicious items.

U.S. & Canada Toll Free: 866-525-1955

International Collect: 603-328-1955

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

IMPORTANT NOTE

PLEASE KEEP THIS BROCHURE AS A GENERAL SUMMARY OF THE

INSURANCE BENEFITS. 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.

Offered and Administered by:



Short Hills, NJ 07078

866-267-0092 (Claims/Coverage)

800-526-1379 (Other Questions)

www.BollingerColleges.com/LincolnUniversity

Local Broker:

Aon Risk Services Central, Inc.

4801 Main, Suite 350

Kansas City, MO 64112

816-698-4649

Underwritten by:

Monumental Life

Insurance Company

Cedar Rapids, Iowa

Policy No. CM0111I

Policy Form SH5000GPM.MO

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