2012-2013
STUDENT INJURY AND SICKNESS INSURANCE PLAN

HAMPDEN-SYDNEY, VA

Read Your Brochure Carefully.

NON-RENEWABLE INSURANCE

The Master Policy on file with the Policyholder becomes effective at 12:01 a.m. on 6/30/12 and terminates at 12:00 a.m. on 8/01/13.

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, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage has a per Injury benefit limit of $2,500 and a per Sickness benefit limit of $1,000. If you purchase the Optional Major Medical coverage your total benefit limit is $10,000. If you have any questions or concerns about this notice, contact Bollinger Insurance Services, 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.

This Plan Underwritten By:
MONUMENTAL LIFE INSURANCE COMPANY
Cedar Rapids, Iowa
a Transamerica company

Administered By:
Bollinger, Inc.

THIS PLAN IS SUBJECT TO THE REGULATION IN THE COMMONWEALTH BY BOTH THE STATE CORPORATION COMMISSION BUREAU OF INSURANCE PURSUANT TO TITLE 38.2 AND THE VIRGINIA DEPARTMENT OF HEALTH PURSUANT TO TITLE 32.1

Visit us on the web: **www.BollingerColleges.com/hsc**
PLEASE GO TO THE STUDENT HEALTH CENTER FIRST
Policy No. CVA213I

ELIGIBILITY

All registered students attending Hampden-Sydney College are automatically enrolled in the Injury and Sickness plan described in this brochure. The fee of $365.00 has been added to your tuition bill. **To be exempt from this coverage and fee, you (the student) are required to show proof of other medical insurance by returning the enclosed waiver card.** IF THE WAIVER CARD IS NOT RECEIVED IN THE BUSINESS OFFICE BY AUGUST 1, 2012 FROM STUDENTS WHO ENTER THE FALL SEMESTER, IT WILL REMAIN AS AN ADDITIONAL CHARGE ON YOUR BILL. Students who enroll for the spring semester must return the waiver card by January 1, 2013.

The Policy protects insured students and their insured dependents on and off campus, at home or while traveling. The Policy is primary to any other insurance the student may carry, **except under the Intercollegiate Sports and Optional Major Medical benefits.**

Eligible persons must enroll in the insurance plan at or prior to the time they enroll in school. Eligible persons desiring to purchase the insurance at other times may only do so as the result of a change in their insurance coverage status such as being dropped from parent's coverage when turning 26, loss of coverage at work, etc. Written proof must be provided prior to insurance coverage acceptance.

Students must actively attend classes for 45 days following the date of enrollment in this insurance program, except during school authorized breaks. Home study, auditing scholars and other non-traditional students do not qualify as a student for the purposes of purchasing this coverage. The Company maintains the right to investigate student status and attendance records to verify if eligibility requirements have been met. If eligibility requirements have not been met, the company's only obligation is a pro-rated refund of premium.

Optional Dependent Coverage **Optional dependent coverage - except for newborns - can only be purchased at the time the basic student coverage is purchased** by completing the enclosed enrollment form and paying an additional premium. It cannot be purchased unless the student is enrolled in the plan. Eligible dependents are the spouse and children up to 26 years of age.

Coverage for Newborn Children is available only under two conditions: 1) If the student purchases Child coverage before the birth of the baby, or 2) If the student purchases spouse coverage when initially enrolling and pays an additional premium for Child coverage within 31 days after the newborn's birth.

Continuation of Coverage: This is a non-renewable policy. It is the insured's responsibility to maintain continuity of coverage by inquiring about such coverage if they have not received the information for the new policy year.

Coverage is not automatically renewed. You are responsible for keeping this insurance policy in force, even though the school makes every effort to send billing notices to all eligible students. Eligible persons must re-enroll prior to coverage terminating to maintain continuous coverage. A gap in coverage may reduce or void benefits.

ALTERNATIVE COVERAGE

If you do not meet the eligibility requirements of this plan, please call 1-866-931-9560 for information on alternative insurance plans.

DEFINITIONS

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

Elective Surgery and Elective Treatment includes but is not limited to surgery and/or treatment for acne; acupuncture; allergy and allergy vials, including allergy testing; bio-feedback type services; birth control; 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 the Policy, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are otherwise payable under the Policy; deviated nasal septum, including submucous resection and/or other surgical correction; 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; sleep disorders, including testing; smoking cessation; tubal ligation; vasectomy; and weight loss or reduction.

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.

SICKNESS means an illness, 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.

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.

PSYCHIATRIC BENEFITS

Usual and Customary Charges for mental and nervous conditions; alcoholism and drug dependency while confined in a Hospital will be paid up to $2,000 per year. Usual and Customary outpatient charges will be paid at 50% up to $30 per visit, maximum $750 per year. Psychiatric Hospitals are not covered. Medications for Mental and Nervous Disorders are not covered.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the 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 of coverage or beyond release from the Hospital for that Inpatient Confinement or the maximum policy benefit whichever occurs first.

STATE MANDATED HEALTH BENEFITS

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

MANDATED BENEFITS

Autism Spectrum Disorder Benefit

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 $1,000 but shall not be subject to any limits on the number or visits to a service provider.

Treatment for Autism Spectrum Disorder shall be identified in a treatment plan and includes the following care prescribed or ordered for a covered Dependent 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.

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.

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 this 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, noninvestigational treatment alternative;
2. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational 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 the 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 relationship 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;
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 noninsulin-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.
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 reestablish 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 the 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 psychotherapy 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 the 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.

MANDATED OFFERS

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 the 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 the 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:

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.

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.

CONDITIONAL MANDATES

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, copayments, 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 the 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 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 the 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.

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 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 College's prior policies for more than 12 months; or
(3) the insured has been receiving benefits under the College's prior policies and has been continuously insured since the date of Injury, or Sickness, whichever occurs first.

INJURY MEDICAL EXPENSE BENEFIT

A. Injury Benefit . . . paid at 100%

Provides payment for Usual and Customary Charges for in-patient and out-patient covered expenses incurred for Medically Necessary treatment and supplies resulting from an Injury first occurring while insured under the Policy. Payment will be made up to $2,500 ($5,000 for Intercollegiate Sports on an excess basis) for each Injury incurred provided such treatment begins within 90 days after the onset of the Injury. Injuries incurred by student athletes participating in regularly scheduled and supervised play, practice, training session or travel to or from the following sports: baseball, basketball, cross country, football, golf, lacrosse, soccer, tennis and swimming. The Intercollegiate Sports coverage also includes expanded medical and HMO, two-year benefit period and coverage for orthopedic equipment and appliances prescribed by a physician. Replacement braces and appliances are not covered.

Also available is an optional **Major Medical** benefit up to $10,000, which is described in this brochure.

B. Sickness Medical Expense Benefit . . . paid at 100% Provides payment for Usual and Customary Charges commencing after the effective date of the Policy and after a $25.00 deductible (per Sickness) has been met for covered in-patient and out-patient services up to $1,000 for each Sickness.

Eligible expenses include but are not limited to:

Outpatient Benefits: 1) Hospital services such as use of the emergency room, x-rays and medical supplies; 2) Ambulance service to and from a hospital; 3) Purchase or rental of specific medical supplies and equipment; 4) Physician services while not hospital confined such as visits (Physician's visits are limited to 15 per Sickness or Injury), x-rays and laboratory fees; 5) Miscellaneous fees and surgeon's fees for necessary services and supplies for outpatient surgery; 6) Pregnancy will be covered the same as any other sickness; 7) Physiotherapy (outpatient Physiotherapy, including manipulation and massage, is limited to 10 visits); 8) Injury to sound and natural teeth; 9) Removal of wisdom teeth up to $200/tooth; and 10) Prescription drugs.

Inpatient Benefits: 1) Semi-private room rate; 2) Miscellaneous hospital charges incurred while an inpatient; 3) Hospital daily intensive care; 4) Graduate registered nurse while hospital confined; 5) Surgeon's fees; 6) Physician's visits while confined in a hospital on non-surgical visits; 7) Pregnancy will be covered the same as any other Sickness; 8) Physiotherapy; 9) Injury to sound and natural teeth; and 10) Removal of wisdom teeth up to $200/tooth.

MAJOR MEDICAL BENEFIT

Optional Major Medical may be purchased by completing the enclosed enrollment card and paying an additional premium. **This coverage can only be purchased at the time the basic student coverage is purchased.** After benefits are paid under the Basic Benefits, and after the Insured has satisfied a $100 deductible, the plan then pays 80% of all remaining eligible expenses up to a Policy maximum of $10,000 (including Basic Benefits).

No benefits under the Major Medical will be paid for: 1) Psychiatric coverage; 2) Physiotherapy; 3) Intercollegiate Sports; and 4) for any expenses incurred which are paid or payable by any Other Valid and Collectible Insurance. Exclusion #3 does not apply to students insured under an HMO when the insured is outside the HMO area of coverage or if the student does not have any other insurance.

STUDENT HEALTH CENTER (SHC) REFERRAL

The student is strongly encouraged to use the resources of the Health Center first where treatment will be administered, or referral issued. A SHC referral for outside care is not necessary under the following conditions: 1) Medical Emergency; 2) When the Student Health Center is closed; 3) When service is rendered at another facility during break or vacation periods; 4) Medical care received when the student is more than 25 miles from campus; 5) Medical care obtained when a student is no longer able to use the SHC due to a change in student status; or 6) Maternity.

Dependents are not eligible to use the SHC. Therefore, they are exempt from the above limitations and requirements.

CONVERSION PRIVILEGE Upon termination of coverage as outlined above, you and your dependents are eligible to continue coverage under the policy at 50 % of the benefits that would have otherwise been payable for a period not to exceed 12 months at the conversion rates in effect at the time of conversion. Contact www.BollingerColleges.com/HSC for further information.

GRACE PERIOD The Policy has a 31 day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the grace period.

EXCLUSIONS & LIMITATIONS

1. Services that are provided normally without charge by the College's health center, infirmary or Hospital; or by any person employed by the College;
2. Routine physical examinations, preventive testing or treatment, screening exams or testing in the absence of Sickness or Injury, pre-marital examinations, preemployment examinations, health examinations or pre-school physical examinations not including routine care of a newborn infant, well baby nursery and related Physician charges, and any associated laboratory work, not including mammograms and routine Papanicolaou cytology test;
3. Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except as required for repair caused by a covered Injury;
4. Expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to natural teeth;
5. Declared or undeclared war, riot, civil disorder, civil commotion;
6. Suicide or attempted suicide while sane or insane, including drug overdose; or intentional self-inflicted Injury;
7. Injury (in excess of $5,000) resulting from the playing, practice, participating, or conditioning in any intercollegiate, interscholastic, intramural contest or competition sponsored by the College, any professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant;
8. Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as fare-paying passenger in an aircraft operated by a commercial scheduled airline. This exclusion does not apply to insured students while taking flight instructions for University credit;
9. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
10. Elective Surgery or Elective Treatment;
11. Elective abortion;
12. Congenital conditions, except for Newborn Children insured under the Policy;
13. Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law;
14. Organ transplants;
15. Assistant surgeon fees; and
16. Expenses incurred for the treatment of and supplies for weight reduction, hair growth or removal, birth control, or smoking cessation.

CLAIM PROCEDURE

In the event of Sickness or Injury, the Insured should:

1. Secure a claim form from: **www.BollingerColleges.com/HSC. Read and follow the instructions on the back of the claim form.**
2. Bills must be received by Bollinger, Inc. within 90 days of service or as soon as reasonably possible to be considered for payment.
3. No claim will be processed until a Bollinger, Inc. claim form is received.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

You have the right to obtain information on types of provider payment arrangements used to compensate providers for health care services rendered to covered persons, including, but not limited to, withholds, bonus payments, capitation, processing fees, and fee-for-service discounts.

We would like to hear from you regarding our services. In addition to our annual survey which will be sent to you, please feel free to contact us by phone or the web using the information below.

For a complete list of providers in our provider panel please visit us on the Web at: www.BollingerColleges.com/HSC
OR
Call the toll-free First Health Provider locator number 24 hours a day, 7 days a week 1-800-226-5116, and we will assist you in locating a contracted provider. This service is available wherever you are located in the country, and is especially useful when you are traveling.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your Plan Administrator for Monumental Life Insurance Company at the following address and telephone number:

Bollinger, Inc.
101 JFK Parkway
Short Hills, NJ 07078-0727
Toll Free 1-800-526-1379

If you have been unable to contact or obtain satisfaction from the Plan Administrator, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Virginia Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
Consumer Services Hotline
877-310-6560 (Toll free and Nationwide)
804-371-9691 (Local)
800-552-7945 (Virginia only toll free)

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your Plan Administrator, company or the Bureau of Insurance, have your policy number available.

Information regarding the Monumental Life procedures for filing an inquiry, grievance or appeal can be obtained at: www.BollingerColleges.com/HSC. 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:

Address:
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: www.scc.virginia.gov/boi.

STUDENT ASSISTANCE SERVICES
(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.

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.

SUBMIT ALL CLAIMS & INQUIRIES TO:

Bollinger
Insurance Solutions

P.O. Box 727
Short Hills, NJ 07078-0727
1-866-267-0092 (Claims/Coverage questions only)
1-800-526-1379 (All other questions)

THIS PLAN IS UNDERWRITTEN BY:
Monumental Life
Insurance Company
Cedar Rapids, Iowa

Preferred Provider Network:

First Health
Network

Local Broker:
Collegiate Risk Management
110 Athens Street
Tarpon Springs, FL 34689
Phone: 1-866-931-9560
Fax: 727-939-8323
www.Collegiaterisk.com

Note: Your canceled check or money order is your receipt. This is a brief description of coverage. The Master Policy will prevail on any discrepancies between this brochure and the Master Policy.

Should an insured student graduate or withdraw from the school, the insurance shall remain in effect until the end of the period for which premium has been received. No return of premium will be made unless the insured enters the armed forces of any country. The Company will refund the unearned prorated premium upon request.

A verbal explanation of benefits does not guarantee payment of claims.
Policy # CVA213I

Policy Form: MLSH5100GP.VA

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