2013-2014
Blanket Injury and Sickness Plan
Designed for the Students of

2500 Rivermont Ave.
Lynchburg, VA 24503

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

THIS PLAN UNDERWRITTEN BY:
MONUMENTAL LIFE
INSURANCE COMPANY
Home Office: Cedar Rapids, Iowa
a Transamerica company

Please keep this outline of coverage for future reference

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

Policy Number: CVA219J
Policy Form: MLSH5100GP.VA

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.

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INTRODUCTION

Hospitalization, surgery and accompanying medical expenses are at an all time high. Many students and their parents are not prepared to meet the added cost of unexpected Injuries and Sicknesses. Although many families have some form of health insurance, these plans often do not cover a college student after age 18 or when the student is out of the provider's area. Costly medical bills can impose tremendous hardship, and even necessitate withdrawal from school.
The College is concerned with the health and well-being of its students. Student Accident and Sickness insurance is designed to provide low-cost coverage for unanticipated medical expenses. Please read the provisions of this insurance plan carefully and retain this brochure for future reference.

ELIGIBILITY

All full-time undergraduate students with a minimum of 12 credit hours and graduate students with a minimum of 6 credit hours are automatically enrolled in this insurance plan, and the cost will be included in the tuition bill unless proof of comparable coverage is furnished before the Waiver/Enrollment Deadline date.

REFUND PROVISION

In the event an Insured person leaves school to enter active military service, coverage will cease and a pro rata refund of premium will be made upon request. Other than as stated here, no refunds are available.

TERM OF COVERAGE

The policy for the current year becomes effective on August 15, 2013 at 12:01 a.m. and expires on August 15, 2014 at 12:00 a.m. Coverage remains in effect during holiday and vacation periods. Should an Insured person graduate or withdraw from the institution, the insurance shall remain in effect until the end of the period for which premium has been paid. The plan protects the Insured students of Randolph College at home, at school, worldwide, 24 hours a day.

WAIVER/ENROLLMENT DEADLINE

If You have proof of comparable insurance and wish to waive coverage, the deadline to waive out of this plan is August 15, 2013. To waive out of this insurance plan, log onto www.BollingerColleges.com/Randolph and follow the instructions.

PLAN COST

Fall Enrollment	
Students Under Age 26	$1,264
Students Age 26 and Older	$1,680
Each Dependent	$1,566

New Student Spring Enrollment	
Students Under Age 26	$859
Students Age 26 and Older	$1,120
Each Dependent	$1,044

Student rates include an administrative fee

DEFINITIONS

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.

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 inpatient 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 Ilness, 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.

INSURED means an eligible student as outlined in this Policy and in the Master Application for whom an application has been received and has paid the required premium. The words he, his, and him refer to the Insured, regardless of gender.

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.

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. Physician shall also include a Dentist performing covered services within the scope of his professional license. He may not be the Insured or a member of his Immediate Family.

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.

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.

CONTINUATION OF COVERAGE

If a Covered student no longer meets the Policy's eligibility requirements, he or she may continue coverage for three (3) months provided the school renews the Master Policy with Monumental Life Insurance Company. The student must notify us that he or she wishes to continue coverage under this Policy and pay any required premium within thirty (30) days of ineligibility under the Policy's requirement.

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 9 months 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 for Applied Behavior Analysis is $35,000 but shall not be subject to any limits on the number or visits to a service provider.

For purposes of this benefit, the following definitions apply:

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

Autism Spectrum Disorder means any pervasive developmental disorder, including

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

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

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

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

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

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

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

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

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

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

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

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

Benefits will be provided on the same basis as any for any other Sickness. Benefits are subject to all Co-payments, Deductibles and limitations of 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 mean a licensed, esidential 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 s54.1-3507.1 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.

MEDICAL EVACUATION BENEFIT

We will pay for Covered Medical Evacuation Expenses incurred if the Insured person suffers an Injury or Sickness that requires Medical Evacuation while on Covered Travel. Benefits payable are subject to a maximum amount per Insured person of $10,000, when pre-approved for all Medical Evacuations due to all Injuries or all Sicknesses from the same or related causes, and this is also the aggregate maximum for all travel benefits including Medically Necessary Transportation and the Repatriation of Remains Benefit and Bedside Visit Benefit. The Physician must order the Medical Evacuation and must certify that the severity of the Insured person's Injury or emergency Sickness warrants his or her Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

MEDICALLY NECESSARY TRANSPORTATION

If the Insured person is hospitalized for more than five consecutive days following a Covered Medical Evacuation, We will pay, subject to any limitations stated herein, for Expenses to return the Insured person from the medical facility to which he or she was treated to the Insured person's return destination, less refunds from the Insured person's unused Transportation tickets. Airfare costs will be economy or first class if the Insured person's original tickets are first class.

REPATRIATION EXPENSE BENEFIT

If the Insured person suffers a covered loss of life while on Covered Travel, We will pay, subject to the limitations stated below, for Covered Expenses reasonably incurred to return the Insured person's body to their home country, but not exceeding a maximum per Insured person benefit amount of $7,500, when pre-approved, and this is also the aggregate maximum for all travel benefits including the Medical Evacuation Benefit and Medically Necessary Transportation and Family Visitation Expense.

Covered Expenses. Covered Expenses include, but are not limited to, Expenses incurred in accordance with the applicable international requirements for: (1) embalming; (2) cremation; (3) the most economical coffins or receptacles adequate for Transportation of the remains; and (4) Transportation, according to airline tariffs, of the remains by the most direct and economical conveyance and route possible.

Benefits will not be provided for any Expense provided by another party at no cost to the Insured person or already included in the cost of the Covered Travel.

We or Our representative must authorize all Expenses in advance for any travel benefit to be payable.

COORDINATION OF BENEFITS

EXPLANATION When a person is covered by more than one Plan, the benefits that are paid will be shared between the Plans. This is done so that the total benefits paid will not be more than 100 percent of the Allowable Expenses for any Covered Person.
In a Policy Year this Policy will pay:
(1) its regular benefits in full; or
(2) a reduced amount of benefits if a Covered Person is covered under more than one Plan. If a reduced amount of benefits is paid using this provision, each benefit that would be payable in the absence of this provision:

a) will be reduced to the same proportion; and
b) the reduced amount will be charged against any benefit limit of this Policy that applies.

EFFECT ON BENEFITS This provision will be used to determine a Covered Person's benefits for any Policy Year when the sum of the following is more than the Allowable Expenses:
(1) the benefit that would be paid under this Policy in the absence of this provision; and
(2) the benefits that would be paid under all other Plans in the absence of similar provisions whether or not a claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service given will be considered as a benefit paid.

The benefits of another Plan that coordinates its benefits with this Policy will be ignored in order to determine the benefits under this Policy if:
(1) another Plan provides that its benefits be paid after the benefits of this Policy; and
(2) this Policy provides that its benefits be paid before such other Plan.

ORDER OF BENEFIT DETERMINATION The Plan that pays first figures its benefits exactly as though duplicate coverage does not exist. The second Plan will pay for Allowable Expenses not covered by the first Plan if this amount is not more than the benefits payable when there is no duplicate coverage.

When two or more Plans contain non-duplication clauses, the order in which the Plans will pay benefits will be as follows:
(1) a Plan that covers the person as other than a Dependent will pay before a Plan that covers the person as a Dependent;
(2) a Plan that covers the person as a Dependent of a person whose birthday falls earlier in a year will pay before a Plan that covers the person as a Dependent of a person whose birthday falls later in that same year, except that:
a) a Plan that covers a child as a Dependent of the parent with custody will pay before a Plan that covers the child as a Dependent of the parent without custody. This occurs when the parents are separated or divorced and the parent with custody has not remarried;
b) a Plan that covers a child as a Dependent of the parent with custody will pay before a Plan that covers the child as a Dependent of the stepparent. A Plan that covers the child as a Dependent of the stepparent will pay before the benefits of a Plan which covers the child as a Dependent of the parent without custody. This occurs when the parents are divorced and the parent with custody has remarried;
c) however, a Plan that covers a child as a Dependent of the parent who is financially liable will pay before any other Plan that covers the child as a Dependent child. This occurs when there is a court decree which would otherwise establish financial liability for the medical, dental or other health care expenses of the child; and
(3) the first Plan to pay when the order of payment cannot be determined by these rules will be the Plan that has covered the person for the longer period of time.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION In order to determine whether this provision applies the Company may:

(1) release or obtain any necessary information from any other organization or person with a legitimate interest;
(2) require any person claiming benefits to furnish such necessary information; and
(3) receive information reasonably related to a claim for benefits under this Plan.

FACILITY OF PAYMENT The Company has the right to make payments to any organizations when payments have been made under any other Plans and should have been made under this Policy. Payment will be in any amount determined by the Company to be warranted. The amounts paid will be considered benefits paid and the Company will be liable only to the extent of payment made.

RIGHT OF RECOVERY The Company may recover any payments it makes in excess of the amount needed to satisfy the intent of this provision from among one or more of the following:
(1) any person that receives payments; or
(2) any other insurance companies or other organizations.

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Insured's Pre-existing Conditions. They are defined as an Injury sustained or a Sickness for which the Insured noticed symptoms or was medically diagnosed, treated (including medication), or advised by a Physician within the six month immediately prior to his Effective Date of Coverage under this Policy. Pre-existing exclusion does not apply to insureds or dependents under the age of 19.

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 this Policy and the College's prior policies for one continuous year; 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.

EXCLUSIONS

1. Expenses incurred as the result of dental treatment, except as specifically provided for Covered Persons under age 19 and for treatment resulting from Injury to natural teeth;
2. Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except for Covered Persons under age 19 or as required for repair caused by a covered Injury;
3. Pre-marital examinations, pre-employment examinations, or pre-school physical examinations;
4. Cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Policy;
5. Elective abortion;
6. Injury resulting from skin diving or sky diving, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
7. Declared or undeclared war, participating in riot, civil disorder, civil commotion; or acts of terrorism;
8. Committing or attempting to commit an assault or felony; or fighting, except in self defense;
9. Injury sustained or Sickness contracted while in the service of the armed forces of any country. When an Insured enters the armed forces, we will refund any unearned pro-rata premium with respect to such person;
10. Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law;
11. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
12. Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate, contest or competition sponsored by the College, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant.

CLAIM FILING PROCEDURES

Claim Procedures

1. Complete a claim form, which is available online at our website, www.BollingerColleges.com/Randolph. Please read and follow the instructions provided on the back of the claim form carefully.
2. The claim form must be completed and signed. Written proofs of loss (itemized bills) must be furnished with the claim within 90 days from the date of loss. Mail the claim to the address on the form.
3. Preauthorization and pre-certification of the benefits to providers of medical service are not required nor provided by us.
4. No claim will be processed until a Bollinger, Inc. claim form is received.

STUDENT ASSISTANCE SERVICES
(Administered by On Call International)

The following services are available for use by he students insured under this plan. For additional information, please refer to the plan web site: www.BollingerColleges.com/Randolph

Nurse Helpline: Clinical assessment, education and general health information performed by a registered Nurse counselor to assist in identifying the appropriate level and source(s) of care for Students. Nurses shall not diagnose a Student's ailments.

Travel Assistance Services: 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-TripInformation; 24/7Emergency 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: On Call International has an Identity Theft Recovery Unit who will listen, document, support, and guide participants who experience identity theft.

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.

PLAN ADMINISTERED BY:

Bollinger
Insurance Solutions

P.O. Box 727
Short Hills, NJ 07078-0727

All questions should by directed to Bollinger at
1-866-267-0092 (Claims/Coverage)
1-800-526-1379 (Other Questions)
or to our website at
www.BollingerColleges.com/Randolph

PREFERRED PROVIDER NETWORK:

First Health Network

This brochure provides a description of your insurance program. You may obtain a complete certificate of insurance, including your appeal rights and grievances procedures, by accessing the link above.

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

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

Monumental Life Insurance Company: Randolph College Student Injury and Sickness Plan

Coverage Period: 08/15/2013 – 08/15/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BollingerColleges.com/Randolph or by calling 1-866-267-0092.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$50 Sickness deductible \ $5,000 Accident deductible** per Policy Year. Does not apply to In-Network preventative and wellness services. Deductible is waived if treatment is provided at or referred by the Student Health Center .	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	No.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	Coverage is limited to $500,000 aggregate maximum per Policy Year. The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.MyFirstHealth.com** or call **1-800-226-5116** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-866-267-0092 or visit us at www.BollingerColleges.com/Randolph
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-267-0092 to request a copy.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amou** e, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	20% co-insurance	Services that are normally provided without charge at the student health center are not covered.
	Specialist visit	20% co-insurance	20% co-insurance	
	Other practitioner office visit	20% co-insurance	20% co-insurance	
	Preventive care/screening/immunization	No charge	20% co-insurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	20% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	20% co-insurance	
If you need drugs to treat your illness or condition More information	Generic drugs	$15 co-payment for generic		

about **prescription drug coverage** is available at www.caremark.com.	Brand name Specialty drugs	$30 co-payment for brand name or $50 co-payment for specialty drugs, per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 co-pay and 20% co-insurance	$150 co-pay and 20% co-insurance	none
	Physician/surgeon fees	$15 co-pay and 20% co-insurance	$15 co-pay and 20% co-insurance	none
If you need immediate medical attention	Emergency room services	$100 co-pay/visit and 20% co-insurance	$100 co-pay/visit and 20% co-insurance	Services that are normally provided without charge at the student health center are not covered. Co-pay waived, if Admitted. Medical Emergency covered at In Network co-insurance amounts
	Emergency medical transportation	20% co-insurance	20% co-insurance	Medical Emergency covered at In Network co-insurance amounts
	Urgent care	20% co-insurance	20% co-insurance	Services that are normally provided without charge at the student health center are not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-pay and 20% co-insurance	$150 co-pay and 20% co-insurance	none
	Physician/surgeon fee	20% co-insurance	20% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	20% co-insurance	none
	Mental/Behavioral health inpatient services	20% co-insurance	20% co-insurance	none
	Substance use disorder outpatient services	20% co-insurance	20% co-insurance	none
	Substance use disorder inpatient services	20% co-insurance	20% co-insurance	none
If you are pregnant	Prenatal and postnatal care	20% co-insurance	20% co-insurance	none
	Delivery and all inpatient services	20% co-insurance	20% co-insurance	none
If you need help recovering or have other special health	Home health care	20% co-insurance	20% co-insurance	Coverage is limited to one visit per day
	Rehabilitation services	20% co-insurance	20% co-insurance	Coverage is limited to one visit per day
	Habilitation services	20% co-insurance	20% co-insurance	Coverage is limited to one visit per day

needs	Skilled nursing care	20% co-insurance	20% co-insurance	Coverage is limited to one visit per day
	Durable medical equipment	20% co-insurance	20% co-insurance	——————none——————
	Hospice service	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Bariatric surgery
- Dental care (Adult)
- Elective Abortion
- Elective Surgery or treatment
- Eyeglasses
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Treatment for Acne

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-866-267-0092. You may also contact your state insurance department at 1-877-310-6560.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Virginia State Corporation Commission's Bureau of Insurance via their website http://www.scc.virginia.gov/boi/complaint.aspx . Or, if you wish to discuss your complaint or receive assistance on how to file a complaint, you can call their toll-free number 1-877-310-6560.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,632
- **Patient pays** $1,908

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$50
Co-pays	$450
Co-insurance	$1,408
Limits or exclusions	$0
Total	**$1,908**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,630
- **Patient pays** $770

Sample care costs:

Prescriptions	$2,900*
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700**
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$510
Co-insurance	$260
Limits or exclusions	$0
Total	**$770**

*Assume $100 per Generic Rx in this scenario

**Assume 5 visits in this scenario

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.