

2012-2013

Student Injury & Sickness Insurance Program

Designed Especially for the Students of



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

The Plan underwritten by:

MONUMENTAL LIFE INSURANCE COMPANY

Cedar Rapids, IA

a Transamerica company

Administered by:

Bollinger
Insurance Solutions

Please visit the plan website at: www.BollingerColleges.com/VIC

Please keep this outline of coverage for future reference.

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

Policy Number: CVA218I

Policy Form: MLSH5100GP.VA

25792710

INTRODUCTION

Hospitalization, surgery and accompanying medical expenses are at an all time high. Many students are not prepared to meet the added cost of an unexpected Injury or Sickness. Costly medical bills can impose tremendous hardship, and even necessitate withdrawal from college. The College is connected with the health and well being of its students. Student Injury 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 students enrolled at Virginia Intermont College are automatically enrolled in this insurance plan, and the cost of \$570 annually (\$285 per semester) will be included in the tuition bill, unless proof of comparable coverage is furnished. Eligible dependents are the spouse and children up to age 26.

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 June 30, 2012 at 12:01 a.m. and expires on August 1, 2013 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 student, and if applicable their dependents, of Virginia Intermont College at home, at school or wherever they are 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 September 30, 2012. To waive out of this insurance plan, log onto www.BollingerColleges.com/VIC and follow the instructions.

PER SEMESTER COST

Student.....	\$285
Spouse	\$768
Child(ren)	\$433

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.

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 illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

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

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.

SICKNESS means an illness or disease 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.

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 \$35,000 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.

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, schizo affective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Bones and Joint Treatment Benefit

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

Cancer Clinical Trial Benefit

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

Coverage of patient care costs will apply only if:

1. There is no clearly superior, non investigational treatment alternative;
2. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the 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 out-patient 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 co-existing 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 in-patient 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; rehabilitative 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.

CONTINUATION OF COVERAGE

If a Covered student no longer meets the Policy's eligibility requirements, he or she may continue coverage for 90 days 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.

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Insured's Pre-existing Conditions. They are defined as an Injury sustained or a Sickness for which the Insured noticed symptoms or was medically diagnosed, treated (including medication), or advised by a Physician within the six months immediately prior to his Effective Date of Coverage under this 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 this Policy and the University's prior policies for two continuous years; or (3) the insured has been receiving benefits under the University's prior policies and has been continuously insured since the date of Injury or Sickness, whichever occurs first.

Maximum Policy Benefit: \$50,000 per Injury or Sickness – The Policy provides benefits for the Eligible Expenses incurred by a Covered Person for loss due to a covered Injury or Sickness up to Maximum Benefit of \$50,000. Benefits will be paid as allocated for each service as scheduled below.

SECTION I, BASIC INJURY & SICKNESS BENEFITS	AGGREGATE MAXIMUM BENEFIT
When you suffer a loss from Injury and Sickness, we will pay the expense incurred up to the aggregate maximum, after a \$50 deductible, per Injury or Sickness. The deductible will be reduced to \$10 with a referral from Student Health Services. Benefits are allocated as follows:	\$1,000
Hospital Room & Board Expense: When your Injury or Sickness requires hospital confinement, we will pay the hospital room and board expense up to the semi-private rate not to exceed the maximum benefit.	\$250 per day
Hospital Miscellaneous Expense: We will pay the expenses incurred by you during a hospital confinement or as an outpatient for day surgery for services provided by a hospital, ambulatory surgical center or ambulatory medical center up to the maximum benefit. We will pay for anesthesia, operating room, laboratory tests, x-rays, oxygen, drugs, medicines, dressings, and other necessary non-room and board expenses.	\$1,000
Surgical Expense: When your Injury or Sickness requires surgery, we will pay the expense based on the FAIR Health survey of surgical fees valued at the 90th percentile subject to the maximum surgical benefit. Only one surgical procedure will be covered when multiple procedures are performed, unless Medically Necessary.	Usual & Customary Expense

SECTION I, BASIC INJURY & SICKNESS BENEFITS	AGGREGATE MAXIMUM BENEFIT
If the surgery requires the services of an anesthetist who is not employed or retained by the hospital in which the surgery is performed, we will pay the loss incurred up to the maximum benefit.	\$250
If the surgery requires the services of an assistant surgeon, we will pay the loss incurred up to the maximum benefit.	\$200
In-Hospital Medical Professional Fees Expense: If, while confined to a hospital, your Injury or Sickness requires the services of a medical professional, we will pay the expense for such services, up to the maximum benefit.	\$80 per day
Outpatient Medical Professional Fees Expense: When your Injury or Sickness requires the services of a medical professional, while not confined to a hospital, we will pay the expense for such services, up to the maximum benefit.	\$80 per visit
Ambulance Expense: When your Injury or Sickness requires the use of an ambulance or air ambulance, we will pay the expense up to the maximum benefit	\$250
Outpatient Diagnostic X-ray and Laboratory Expense: When your Injury or Sickness requires diagnostic x-ray including ultrasound, MRI and CAT Scan, or laboratory services, under the medical professional's direction, we will pay the expense up to the maximum benefit.	\$500
Hospital Outpatient Expense: When your Injury or Sickness requires the use of outpatient facilities of a hospital for an emergency room, under the medical professional's direction, we will pay the expense up to the maximum benefit.	\$500
Outpatient Prescribed Medicines Expense: When your Injury or Sickness requires prescribed medicines, we will pay the expense, up to the maximum benefit. This shall include coverage of a drug for a particular indication that has not been approved by the United States Food & Drug Administration if the Health Resources Commission determines that the drug is recognized effective for the treatment of that indication. Coverage includes expenses for any prescribed drug or device that is FDA approved as a contraceptive.	\$100 per cause

SECTION II, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	MAXIMUM BENEFIT														
<p>Accidental death and dismemberment insurance covers you for a loss as shown below. The loss must result from an accident, directly and independently of all other causes. The accident must take place while you are insured under the policy. Also, the loss must take place within 52 weeks after the accident. The following table shows the amount we will pay:</p> <table data-bbox="123 1629 1008 1871"> <thead> <tr> <th>For loss of</th> <th>Amount</th> </tr> </thead> <tbody> <tr> <td>Life</td> <td>\$1,000</td> </tr> <tr> <td>Both hands or both feet or sight of both eyes</td> <td>\$1,000</td> </tr> <tr> <td>One hand and one foot</td> <td>\$1,000</td> </tr> <tr> <td>One hand and sight of one eye.....</td> <td>\$1,000</td> </tr> <tr> <td>One foot and sight of one eye.....</td> <td>\$1,000</td> </tr> <tr> <td>One hand or one foot or sight of one eye</td> <td>\$ 500</td> </tr> </tbody> </table> <p>The most we will pay for all losses to an insured as the result of one accident is \$1,000. Loss to hands and feet means severance at or above the wrist or ankle joints. Loss of sight means total and irrecoverable loss of sight.</p>	For loss of	Amount	Life	\$1,000	Both hands or both feet or sight of both eyes	\$1,000	One hand and one foot	\$1,000	One hand and sight of one eye.....	\$1,000	One foot and sight of one eye.....	\$1,000	One hand or one foot or sight of one eye	\$ 500	\$1,000
For loss of	Amount														
Life	\$1,000														
Both hands or both feet or sight of both eyes	\$1,000														
One hand and one foot	\$1,000														
One hand and sight of one eye.....	\$1,000														
One foot and sight of one eye.....	\$1,000														
One hand or one foot or sight of one eye	\$ 500														

**SECTION III,
SUPPLEMENT EXPENSE BENEFIT**

If the covered medical expense for your Injury or Sickness exceeds the aggregate maximum we owe under the basic Injury or basic Sickness benefits, we will pay 80% of the expense up to a maximum benefit. Covered expenses for daily hospital room and board will not be more than the usual semi-private room charge.

80% to
\$49,000

EMERGENCY EVACUATION BENEFIT

We will pay for Covered Emergency Evacuation Expenses incurred if the insured person suffers an Injury or Sickness that requires Emergency Evacuation while on Covered Travel. Benefits payable are subject to a Maximum Amount per Insured Person of \$50,000 for all Emergency Evacuations due to all Injuries from the same accident or all Sicknesses from the same or related causes, and this is also the Aggregated Maximum for all travel benefits including Medically Necessary Transportation, Family Visitation Expense, and the Repatriation of Remains Benefit.

MEDICALLY NECESSARY TRANSPORTATION

If the Insured person is hospitalized for more than 5 consecutive days following a Covered Emergency 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 OF REMAINS 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 \$50,000, and this is also the Aggregated Maximum for all travel benefits including the Emergency Evacuation Benefit, 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) cremating; (3) the most economical coffins or receptacle adequate for transportation of the remains; and (4) transportation, according to airline tariffs, of the remain 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 representatives 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: will be reduced to the same proportion; and 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 benefits 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 co-ordinates 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 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; 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; 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.

EXCLUSIONS:

Except as specifically provided under this Policy, benefits will not be paid under this Policy and any attached Rider for any expenses which result from:

1. expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to natural teeth;
2. services that are provided normally without charge by the University's health center, infirmary or Hospital; or by any person employed by the College;
3. eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except as required for repair caused by a covered Injury;
4. routine physical examinations, preventive testing or treatment, screening exams or testing in the absence of Sickness or Injury, pre-marital examinations, pre-employment examinations, health examinations or pre-school physical examinations including routine care of a newborn infant, well baby nursery and related Physician charges, other than Hospital nursery expense of a newborn baby, and any associated laboratory work, not including mammograms and routine Papanicolaou cytology test;
5. cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment within 24 hours of the Injury. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Policy;
6. elective abortion;
7. Injury resulting from racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
8. declared or undeclared war, riot, civil disorder, civil commotion or acts of terrorism;
9. suicide or attempted suicide while sane or insane, including drug overdose; or intentional self-inflicted Injury;
10. 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;
11. Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law;
12. Injury sustained or Sickness contracted as a result of the use of alcohol or the misuse of drugs, medicines, or narcotics or hallucinogen, unless taken in the dosage and for the purpose prescribed by the Covered Person's Physician;
13. treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
14. Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate 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.

STUDENT ASSISTANCE SERVICES
(Administered by On Call International)

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

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-Trip Information; 24/7 Emergency Travel Arrangements; Translation Assistance; Emergency Travel Funds Assistance; Worldwide Legal Assistance; Lost/Stolen Travel Documents Assistance; Emergency Message Forwarding; and Lost Luggage Assistance.

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

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

Identity Theft Recovery Assistance: 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.

CLAIM PROCEDURES

In the event of an Injury or Sickness:

1. Complete a claim form, which is available on-line at our website, www.BollingerColleges.com/VIC. 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.

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

PLAN ADMINISTERED BY:



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

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

PREFERRED PROVIDER NETWORK:



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.