STUDENT HEALTH INSURANCE

Designed Especially For The Students of

UNION PRESBYTERIAN SEMINARY

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

School Year 2013-2014

Please read your summary of coverage.
Policy No. CVA210J

Visit us on the web: www.BollingerColleges.com/union

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

Eligibility
Union Presbyterian Seminary requires all full-time students (see "Course Loads and Full-Time Status" section of the Union Presbyterian Seminary catalog for definition of full-time student) to have health insurance coverage and to show proof of health insurance coverage at the beginning of the fall and spring terms.

Students enrolled in the health insurance plan offered by Union Presbyterian Seminary will make payment to the Union Presbyterian Seminary business office. The cost of insurance coverage will be billed to individual accounts.

Questions concerning eligibility can be answered by contacting Bollinger, Inc. at 800-526-1379 or please contact the Enrollment Management Director.

Effective and Termination Dates
The Master Policy on file at the school becomes effective at 12:01 a.m. July 1, 2013. The Master Policy terminates at 12:00 midnight, July 1, 2014. Your insurance will end for you and your dependents on the earliest of the day you are no longer in an eligible class, you become full time active duty in any armed forces, you reach the end of the period for which the premium was paid, the Policy is terminated, or the date the subscriber ceases to be a participant under the Policy. Students who re-enroll within 30 days of the effective date of coverage will not experience an interruption in coverage.

Continuous Coverage
Continuous coverage means that period of time during which the Insured Person maintains Continuous Coverage under one of the Union Presbyterian Seminary Student Injury and Sickness plans, with no lapse in coverage between the Policy and the prior policies.

Previously insured dependents and students must re-enroll for coverage within 30 days of the end of the prior coverage in order to avoid a break in coverage for conditions which existed in prior Policy years. Once a break in Continuous Coverage occurs, the definition of Injury or Sickness will apply in determining coverage of any condition which existed during such break.

Enrollment
The student insurance fee for this Plan will be billed to your individual student account on a monthly basis, unless coverage is waived by you and proof of comparable, alternate coverage is provided. For questions about enrollment or waiving coverage under this Plan, please contact Michelle Walker at mwalker@upsem.edu.

Certificate of Creditable Coverage
Your coverage under this health Plan is "creditable coverage" under Federal law. When your coverage terminates, you can request a Certificate of Creditable Coverage, which is evidence of your coverage under this health Plan. You may need such a certificate if you become covered under a group health Plan or other health Plan within 63 days after your coverage under this health Plan terminates. If the subsequent health Plan excludes or limits coverage for medical conditions you have before you enroll, this Certificate may be used to reduce or eliminate those exclusions or limitations. In order to obtain a Certificate of Creditable Coverage, please contact Bollinger, Inc. at 800-526-1379.

Rates

	Monthly Fee
Student	**$285**
Each Dependent	**$332**

Medical Expense Benefits
The Student Health Insurance Program Covers eligible expenses for Sicknesses and Injuries up to an aggregate $500,000 maximum benefit per policy year at 80% Coinsurance after a $100 deductible.

Scope of Coverage

If a Covered Person incurs Covered Medical Expenses for any of the services on the Schedule of Benefits, we will pay the Covered Medical Expenses incurred, subject to the deductible amount and benefit percentage on a primary basis. The first Covered Medical Expense must be incurred within the benefit period stated on the Schedule of Benefits. The total of all medical benefits payable under the Policy is shown on the Schedule of Benefits and is subject to the specific maximums shown on the Schedule of Benefits.

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

Special Provider Arrangement

By enrolling in this Plan, you have the First Health Provider Network available to you and your dependents. Use of a Provider in the First Health Network is optional, however you may reduce your out-of-pocket expenses, as network providers have negotiated to accept lower fees as payment for their services.

You can obtain a listing of participating Providers and facilities on the internet at www.BollingerColleges.com/union, or by contacting First Health at 800-226-5116.

Extension of Benefits After Termination

The coverage provided under this Policy ceases on the termination date. However, if under the care and treatment of a Physician, benefits will be provided for a Covered Person for up to 90 days past the expiration date of the Covered Person's coverage under this Policy.

How to File Your Claims

Itemized bills should be sent to the Bollinger, Inc., Claims Department. Use the student insurance website www.BollingerColleges.com/union and/or Bollinger's toll-free number 866-267-0092, for inquiries. I.D. Cards will be provided and will include the necessary information for submitting bills.

Bollinger, Inc.
P.O. Box 727
Short Hills, NJ 07078

Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason if it is shown that written proof of the loss was given as soon as reasonably possible.

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

If You Have Questions

Remember, your coverage will pay more of the cost of your covered medical bills if you seek treatment from a PPO Provider. Here are some numbers you'll want to keep handy:

First Health: 1-800-226-5116 (PPO Provider Information)
Bollinger: 1-866-267-0092 (Claims/Coverage Questions)
1-800-526-1379 (Other Questions)

Exclusions and Limitations:

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

1. Declared or undeclared war, riot, civil disorder, or civil commotion;
2. 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;
3. Committing or attempting to commit an assault or felony, or fighting, except in self-defense;
4. Injury resulting from skin diving or sky diving, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
5. Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;
6. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
7. Injury sustained or Sickness contracted as a result of the use of alcohol or the misuse of drugs, medicines, or narcotics, unless taken in the dosage and for the purpose prescribed by the Covered Person's Physician;
8. Elective Surgery or Elective Treatment;
9. Injury or Sickness for which benefits are payable under any Worker's Compensation or Occupational Disease Law;
10. Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate, interscholastic sport, contest or competition sponsored by the School, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant;
11. Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except for Covered Person under age 19 or as required for repair caused by a covered Injury;
12. Expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to, natural teeth;
13. Elective abortion;
14. Alcohol intoxication, as defined in the state where the Injury occurred;
15. Taking of any drug, medication, narcotic or hallucinogen unless as prescribed by a physician;
16. Taking of alcohol in combination with any drug, medication or sedative;
17. Expenses incurred for experimental infertility procedures and fertility tests unless caused by Sickness;
18. Expenses incurred in connection with sterilization or sterilization reversal, including surgical procedures, exams and devices;
19. Expenses incurred for treatment of and supplies for weight reduction (except for counseling, screening or behavioral interventions for obesity), hair growth or removal;
20. Services and supplies not Medically Necessary for the diagnosis recommended by the attending physician;
21. Hospital care (admission tests, supplies or continued care), medical care, rehabilitation, or any other treatment, procedure, facility, equipment, drug, device, supply or service which we determine is not Medically Necessary. We have the right to deny payments if a Physician or Hospital does not supply medical records required to determine Medical Necessity. We also have the right to deny or reduce payment if the records supplied do not provide adequate justification for performing the service;
22. Surgical, medical or other services of a Physician; surgeon or other person who is not legally qualified or licensed according to relevant sections of Virginia General Laws or other governing bodies;

Pre-Existing Condition Limitation

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

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

(1) A Covered Person is under 19 years of age;
(2) twelve consecutive months have elapsed during which no medical treatment or advice is given by a physician for such condition; or
(3) the Insured has been insured under the Policy or the University's prior policies for more than 12 months; or
(4) 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.

Credit For Prior Coverage

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

Any Pre-Existing Condition limitation is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the Insured Person as of the enrollment date, for similar services covered under the Policy and the prior coverage.

Definitions

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

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

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

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

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

Injury means bodily injury caused by an accident. The Injury must occur while the covered person's insurance is in force under the Policy. All Injuries, sustained by one person for 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 a Sickness.

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

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

Sickness means an illness or disease which first manifests itself while the Policy is in force which results in covered medical expenses. All related conditions and 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 Charges 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.

Mandated Benefits

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

Autism Spectrum Disorder

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

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

For purposes of this benefit, the following definitions apply:

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

Autism Spectrum Disorder means any pervasive developmental disorder, including

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage of patient care costs will apply only if:

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

3. The Covered Person and the Physician or health care provider who provides services to the Covered Person, conclude that participation in the clinical trial would be appropriate, pursuant to procedures established by Us as disclosed in this Policy and evidence of coverage.

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

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

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the 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;
3. Radiologic imaging in accordance with the most recently published recommendations established by the American College of Gastroenterology in consultation with the American Cancer Society.

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

Dental Anesthesia Benefit
Benefits will be payable for Medically Necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a Covered Person who is:
1. determined by a licensed dentist in consultation with the Covered Person's treating Physician to require general anesthesia and admission to a Hospital or outpatient surgery facility to effectively and safely provide dental care; and
2. under the age of 5; or
3 severely disabled; or
4. has a medical condition and requires admission to a Hospital or outpatient surgery facility and general anesthesia for dental care treatment.

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

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

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

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

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

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

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

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

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

Hysterectomy Benefit
Benefits will be payable for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy. Benefit will include a minimum stay in the Hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy.

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

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

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

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

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

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

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

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

Mammogram means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

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

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

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

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

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

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

1. treatment of an adult as an inpatient at a Hospital, inpatient unit of a Mental Health Treatment Center, Alcohol or Drug Rehabilitation Facility or Intermediate Care Facility for a minimum period of 20 days per policy year.
2. treatment of a Child or Adolescent as an inpatient at a Hospital, inpatient unit of a Mental Health Treatment Center, Alcohol or Drug Rehabilitation Facility or Intermediate Care Facility for a minimum of 25 days per policy year;
3. up to 10 days of inpatient benefit described in (1) and (2) may be converted when Medically Necessary at the option of the Covered Person or parent of a Child or Adolescent receiving such treatment to a Partial Hospitalization. The Benefit shall be no less favorable than an exchange of 1.5 days of Partial Hospitalization coverage for each inpatient day of coverage and includes:

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

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

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

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

Definitions:

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

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

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

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

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

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

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

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

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

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

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

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

Treatment means services including diagnostic evaluation, medical, psychiatric and psychological care, and 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 this Policy who is 40 years of age or older and at high risk for prostate cancer or for covered males who are age 50 and over. Prostate cancer screening tests must be performed according to the most recent published guidelines of the American Cancer Society.

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

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

Exclusion:
The following exclusion is in addition to any exclusion found in the Policy:
Reimbursement will not be made to the treating provider or the consulting provider for technical fees or costs for the provision ofTelemedicine Services.

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

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

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

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

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

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

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

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

Prosthetic Device Benefit
Benefit shall be provided for Medically Necessary prosthetic devices, their repair, fitting, replacement, and components, as follows:
1. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

Early Intervention Services means Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of the Department of Behavioral Health and Developmental Services as eligible for services.
Medically Necessary early intervention services for the population certified by the Department of Mental Health, the Department of Behavioral Health and Developmental Services means those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

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

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

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

Mental Health 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 minimum of 20 visits for Outpatient Treatment of an Adult, Child or Adolescent per each policy year;

   b) Benefits are subject to the same Deductible and co-payment as any other Sickness covered under this Policy and limits shall be no more restrictive than the limits of benefits applicable to any other Sickness. Benefits will be provided at the same level as any other Sickness for Covered Persons for outpatient mental health and Substance AbuseServices on the following basis:
   1. A minimum of 20 visits for Outpatient Treatment of an Adult, Child or Adolescent per each policy year.

24-HOUR NURSE HELPLINE
(Administered by On Call International)

On Call shall provide Students enrolled in this Plan with clinical assessment, education and general health information. This service shall be performed by a registered Nurse counselor to assist in identifying the appropriate level and source(s) of care for Students (based on symptoms reported and/or health care questions asked by or on behalf of Students). Nurses shall not diagnose Student's ailments.

U.S. & Canada Toll Free: 866-525-1955 / International Collect: 603-328-1955

Note: The 24-Hour Nurse Helpline is not insurance. It is not connected with or provided by Monumental Life Insurance Company.

TRAVEL ASSISTANCE PROGRAM
(Administered by On Call International)

On Call shall provide each Insured Student and his/her enrolled Dependents with travel assistance services when traveling 100 miles or more away from their home and campus address. Travel Services are only available for medical claims that are covered under the College's Student Accident and Sickness Insurance Plan.

Services provided include:

- Emergency Medical Transportation (Evacuation/Repatriation)
- Medical Monitoring
- Medical, Dental, & Pharmacy Referrals
- Deposit, Advance, & Payment Guarantees
- Dispatch of Medicine, Physician, or Nurse
- Return of Deceased Remains
- Return of Minor Children Assistance
- Pre-Trip Information
- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Worldwide Legal Assistance
- Lost/Stolen Travel Documents Assistance
- Emergency Message Forwarding
- Lost Luggage Assistance

U.S. & Canada Toll Free: 866-525-1955 / International Collect: 603-328-1955

Note: The Travel Assistance program is not insurance. It is not connected with or provided by Monumental Life Insurance Company.

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

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

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

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

Submit all claims or inquiries to:

Bollinger
Insurance Solutions

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

Preferred Provider Network:

First Health Network

1-800-226-5116

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

This Brochure is based on Policy
CVA210J

Policy Form: MLSH5100GP.VA

26135529

Monumental Life Insurance Company: Union Presbyterian Seminary Student Injury and Sickness Plan

Coverage Period: 07/01/2013 – 07/01/2014

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/union** or by calling 1-866-267-0092.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100 in network \ $100 out of network** per Policy Year. Does not apply to In-Network preventative and wellness services.	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**.
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.

Questions: Call 1-866-267-0092 or visit us at www.BollingerColleges.com/union
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.

Monumental Life Insurance Company: Union Presbyterian Seminary Student Injury and Sickness Plan

Coverage Period: 07/01/2013 – 07/01/2014

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

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**

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

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.

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 about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$15 co-payment for generic		
	Brand name Specialty drugs	$35 co-payment for brand name or $50 co-payment for specialty drugs, per prescription		

Questions: Call 1-866-267-0092 or visit us at www.BollingerColleges.com/union

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.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	20% co-insurance	none
	Physician/surgeon fees	20% co-insurance	20% co-insurance	none
If you need immediate medical attention	Emergency room services	$300 co-pay/visit and 20% co-insurance	$300 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	0% co-insurance	0% 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)	20% co-insurance	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 other outpatient services	20% co-insurance other outpatient services	none
	Mental/Behavioral health inpatient services	20% co-insurance	20% co-insurance	none
	Substance use disorder outpatient services	20% co-insurance other outpatient services	20% co-insurance other outpatient services	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 needs	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
	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 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** $5,232
- **Patient pays** $2,308

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	$100
Co-pays	$900
Co-insurance	$1,308
Limits or exclusions	$0
Total	**$2,308**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,705
- **Patient pays** $695

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	$435
Co-insurance	$260
Limits or exclusions	$0
Total	**$695**

*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.