

EXCLUSIONS AND LIMITATIONS

Pre-existing conditions are excluded. Pre-existing conditions means: (1) a condition that manifests itself during the 6 month period immediately preceding the covered person's effective date under the policy that would cause an ordinarily prudent person to seek care, treatment, services or diagnosis, or (2) for which medical advice, diagnosis, care or treatment was recommended or received within 6 months immediately prior to the Covered Person's effective date under the Policy. Pre-existing condition includes a pregnancy existing on the effective date of coverage for Covered Persons who do not qualify as Eligible Individuals. The definition of Pre-existing Condition does not apply to newborns or newly adopted children covered within 30 days of their birth, adoption or legal placement for adoption. A Pre-existing Condition will be covered under the Plan once an insured has been continuously insured under the Student Insurance Plan for at least 12 consecutive months.

A waiver of this pre-existing condition waiting period will be provided for "Eligible Individuals." To qualify as an Eligible Individual, you (or your dependent if eligible under the plan) must meet all of the following requirements: a) must not be covered under any other health insurance; b) must have had health insurance for a total of at least 18 months with no break in coverage of more than 63 days immediately prior to your enrollment date in this plan; c) most recent coverage was under individual health insurance, a group health plan, United States governmental plan or church plan or health insurance offered in connection with any such plan; and d) must not be eligible for coverage under Medicare or Medicaid. When individual health insurance coverage is the most recent Creditable Coverage and when such coverage was non-renewed because the insurer stopped offering health insurance in the individual market, the total period of Creditable Coverage required is reduced from 18 months to 12 months. If you believe you may meet these requirements, please submit a letter of creditable coverage (from your prior carrier with the claim).

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1. Elective treatment; routine physical examinations and routine testing; experimental treatment; preventive testing or treatment (except as specifically stated under Description of Benefits).
2. Services rendered by providers not covered by the Policy such as members of your immediate family.
3. Dental treatment, except for accidental injury to sound, natural teeth as specifically stated; (Please refer to the information regarding Optional Basic Dental Plan available). Injury as a result of chewing or biting will not be considered an accidental injury. Treatment of temporomandibular joint dysfunction and removal of impacted wisdom teeth.
4. Mental Health & Substance Abuse Care Services, except as specifically provided for the conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition).
5. Services provided or available to you: (a) under a U. S. Government program or program for which the federal or state government pays all or part of the cost; or (b) under Medicare or any similar program authorized by state or local laws or regulations or any future amendments to them.
6. Services for injuries or diseases related in any way to employment.
7. Services for artificial insemination, in-vitro fertilization, or any type of artificial or surgical means of conception.
8. Acupuncture.

9. Cosmetic surgery, elective surgery or treatment, or complications therefrom, (elective surgery does not mean a cosmetic procedure required to correct an injury for which benefits are otherwise payable under the policy).
10. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing.
11. Tubal ligation; vasectomy; circumcision; breast reduction; breast implants; orthognathic surgery including mandibular retrognathia; submucous resection and/or surgical correction for deviated nasal septum; weight reduction and/or biofeedback programs; and congenital birth defects, except as specifically provided for a newborn infant.
12. Maternity services rendered to dependent children.
13. Travel, whether or not recommended by a physician.
14. Conditions related to autistic disease of childhood, learning disabilities, behavioral problems, mental retardation or hospitalization for environmental changes.
15. Services provided by the Health Service of the Policyholder or any person employed or retained by the Policyholder for which a student has no obligation to pay in the absence of insurance. If a student does not meet full-time status while covered by the policy, the user fee assessed by the Health Center is not a covered item.
16. Services in excess of \$500 per policy year for the detection and correction by manual or mechanical means of structural imbalance or subluxation.
17. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competitions; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition (but, this exclusion does not apply to injuries sustained while participating in intramural, extramural or club sports programs).
18. Services for Private Duty Nursing and Skilled Nursing Facility.
19. Treatment of obesity, except for surgical Treatment or morbid obesity as determined by the Company.
20. Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; or refractive errors, except as may be provided under the "Expanded Benefits Option."

ANNUAL PREMIUM RATES

(8/1/2003 - 8/1/2004)

- PLAN 1** - \$50,000 Maximum Benefit
Student - \$936.00
- PLAN 2** - \$100,000 Maximum Benefit
Student - \$1,005.00
- PLAN 3** - \$250,000 Maximum Benefit
Student - \$1,078.00
- PLAN 4** - \$5,000 Maximum Benefit (Accident Only)
Student - \$273.00
- EXPANDED BENEFITS**
Student - \$310.00

Premium rates for other membership categories can be obtained in the Insurance Brochure or online at www.gmsouthwest.com.



2003/2004

Health Insurance Plain and Simple

Underwritten By:

clarendon **insurance**
Group

This document is not a complete description on the health insurance plan sponsored by Virginia Tech. A complete description is available online at www.gmsouthwest.com

YOUR STUDENT INSURANCE BENEFITS

MAXIMUM BENEFITS -----	Choose one: (See Application) Plan 1 — \$50,000 maximum per policy year per participant Plan 2 — \$100,000 maximum per policy year per participant Plan 3 — \$250,000 maximum per policy year per participant Plan 4 — Accident Only Coverage - \$5,000 per policy year per participant Expanded Benefits - If elected with Plan 1, 2 or 3 maximum benefits for specific services are as outlined below. Once elected, expanded benefits may not be discontinued until policy expiration at policy year's end.
DEDUCTIBLE ----- YOUR COINSURANCE -----	\$200 per person per policy year. (Maximum \$400 aggregate family deductible) After you have satisfied your deductible, you pay a certain percentage of the Allowable Charge. This is Your Coinsurance. The Allowable Charge is the maximum amount Clarendon National Insurance Company will pay a provider for a covered service, subject to the schedule below. \$10 with referral, \$25 without referral (\$10 for dependents and enrolled students not required to pay a health fee)
OUTPATIENT PHYSICIAN COPAY ----- HOSPITAL ADMISSION DEDUCTIBLE ----- EMERGENCY ROOM DEDUCTIBLE -----	\$300 per hospital inpatient admission. \$100 per emergency room visit (which would be waived if admitted to the hospital)
IMPORTANT NOTE FOR STUDENTS -----	After you have satisfied your deductible, you can enhance your benefits if you first obtain a referral from the Student Health Center and seek care from Montgomery Regional Hospital, Lewis-Gale Hospital, or professional providers who contract with the Alliance Network. A Provider Listing is available at Student Health. This service is only available to those students paying a health fee.
PREVENTIVE SERVICES -----	Mammography Screening ----- 20% / 35% of the Allowable Charge (For one baseline mammogram for persons between 35-39 and an annual mammogram for persons 40 and older or more frequently based on the physician's recommendation.) Pap Test (traditional Pap Test or the Thin Prep Pap Test) ----- 20% / 35% of the Allowable Charge (Limited to one per policy year). Prostate Specific Antigen Test ----- 20% / 35% of the Allowable Charge (Limited to one per policy year). Annual Digital Rectal Examination ----- 20% / 35% of the Allowable Charge (Limited to one per policy year). Well Baby Visits ----- \$30 per visit for up to 6 visits the first 12 months after delivery and for 3 visits from 12 to 24 months after delivery, assuming the additional dependent coverage is purchased for this new dependent.
EXPANDED BENEFITS ----- <i>These benefits are only available if you purchase Plan 1, 2 or 3 and choose to purchase the Expanded Benefits and pay the additional Expanded Benefit premium. If declined at policy inception Expanded Benefits can only be added with the occurrence of a qualifying event such as a change in marital status or change in student's number of eligible dependents.</i> <i>Students may choose to pay all benefits on an annual or quarterly basis.</i> <i>If a student chooses quarterly payments the student must understand that they, even if they leave Virginia Tech, are expected to complete the remaining quarterly payments, as coverage is effective until 7/31/04.</i>	Dental - 100% Prev/80% Basic/50% other - \$75 per person/per year deductible and a \$600 policy year maximum per person. Vision - \$30 per Routine Eye Refraction Exam (to include glaucoma test) and \$50 towards frames, lenses or contact lenses. One per year. Screenings and Tests - Fecal Occult Blood Test and Cholesterol Screening - One Each Per Calendar Yr. Flu Shots - 1 per year
ACCIDENT/SICKNESS BENEFITS -----	YOUR COINSURANCE -----
Prescription Drugs -----	\$10 copayment for each generic; \$20 copayment for each Formulary brand; \$35 copayment for each Non-Formulary brand prescription or refill. (\$1,000 maximum benefit per member per contract year). Member must use participating pharmacy. Contraceptives will be covered as a prescription drug.
Hospital/Facility Benefits ----- Room Allowance, including special diets and general nursing services in a hospital or substance abuse treatment facility ----- Hospital Care for Sickness, Injury or Pregnancy Related Conditions ----- Inpatient Mental Health Services including drug and alcohol treatment (25 days maximum per policy year) following pre-authorization ----- Partial Day Psychiatric Care Program (10 inpatient days may be converted to a maximum of 15 partial days when medically necessary—pre-authorization required) ----- Ancillaries (Operating, treatment and recovery room, drugs and medications, anesthesia, lab and x-ray) ----- Hospital Outpatient Care -----	In / Out of Preferred Provider Network 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge
Physician's Care and Medical / Surgical Benefits ----- Inpatient Medical Service care of sickness and accident ----- Surgical, Surgical Assistant, Obstetrical, Anesthesia, Pathological, Consultative, Lab and Radiological Services ----- Outpatient Diagnostic Services ----- Pre- and Post-Natal Care ----- Physician Outpatient Care for Accidental Injury, surgery, radiological therapy, chemotherapy (not oral), Medical emergencies, and necessary office ----- Outpatient Mental Health Services including drug and alcohol treatment ----- Outpatient Physical Therapy ----- Chiropractic Services -----	In / Out of Preferred Provider Network 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge for the first 5 visits, then 50% / 50% for the next 15 visits — maximum 20 visits. (Note: any visits where total allowed amounts have been applied to the deductible do not apply to the 20 visit maximum.) 20% / 35% of the Allowable Charge 20% / 35% of the Allowable Charge (\$500 max.)
Other Health Care Benefits ----- Other Covered Services, including durable medical equipment, and the cost of blood, blood plasma, blood derivatives and home health care ----- Early Intervention Service ----- Ambulance Services -----	In / Out of Preferred Provider Network 20% / 35% of the Allowable Charge 20% of the Allowable Charge (\$5,000 policy year maximum for early intervention services for covered dependents from birth to age 3.) This service is for state approved insured persons only. 20% / 35% of the Allowable Charge