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BACK COVER FOR DETAILS.**

2011-2012 STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of



**WILLIAM
& MARY®**

NOTICE:

This Plan is subject to regulation by the Virginia Department of Health and the Bureau of Insurance.

The Plan is Underwritten by
UnitedHealthcare Insurance Company



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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 800-767-0700 or by visiting us at www.uhcsr.com/wm.

Eligibility

All International students are required to purchase the Basic Benefits of this insurance Plan and the premium for coverage is added to their tuition billing.

All full-time domestic undergraduate students and domestic graduate students are automatically enrolled in the Basic Benefits of this insurance Plan at registration and premium for coverages added to their tuition billing, unless proof of comparable coverage is provided. All Visiting Faculty Scholars and Graduate Research and Graduate Teaching Assistants who are approved by the College to pursue academic work are required to purchase the Basic Benefits of this insurance Plan, unless proof of comparable coverage is furnished.

All other domestic full-time undergraduate or graduate students are eligible to enroll in this insurance Plan.

All insured students may purchase one of two Major Medical benefit plans on an optional basis. See page 11 for Optional Major Medical benefits.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the policy Eligibility requirements have been met.

If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse and unmarried children under 19 years of age or 25 years if a full-time student at an accredited institution of higher learning, who are not self-supporting. A dependent child enrolled as a full-time student who is unable to continue as a full-time student due to a medical condition will continue to remain dependent until the earlier of the date that is 12 months from the date the dependent child ceases to be a full-time student or the date the dependent child no longer qualifies as a dependent child under the terms of the policy. Dependent Eligibility expires concurrently with that of the Insured student.

Optional Coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment in the Plan. Only those students enrolled in Basic coverage may purchase Optional Major Medical coverage. Students may purchase optional coverages for themselves or for themselves and all family members.

Effective And Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2011. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., July 31, 2012. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Coverage expires as follows:

| | |
|----------------------|-----------------------------|
| Annual | 08-01-11 to 07-31-12 |
| Fall | 08-01-11 to 01-15-12 |
| Spring/Summer | 01-16-12 to 07-31-12 |
| Summer | 05-28-12 to 07-31-12 |

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the coverage expiration date. It is the student's responsibility to make timely renewal payments to avoid a lapse in coverage.

Refunds of premiums are allowed only upon entry into the armed forces. The Policy is a Non-Renewable One Year Term Policy.

Extension of Benefits After Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured 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 as follows provided the condition continues:

- 1) under the Basic Plan, not to exceed 90 days after the Termination Date; or
- 2) under the Major Medical Plan, not to exceed 12 months after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

If the Insured is also an insured under the succeeding policy issued to the Policyholder; this "Extension of Benefits" provision will not apply.

Student Health Center (SHC) Referral Required

(Students Only)

The student must use the resources of the Student Health Center (SHC) first where treatment will be administered, or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage.

A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary only under the following conditions:

- 1) Medical Emergency. The student must return to SHC for necessary follow-up care;
- 2) When the Student Health Center is closed;
- 3) When service is rendered at another facility during break or vacation periods;
- 4) Medical care received when the student is more than 10 miles from campus;
- 5) Medical care obtained when a student is no longer able to use the SHC due to a change in student status;
- 6) Maternity; or
- 7) Psychotherapy.

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

Pre-Admission Notification

UMR Care Management should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide the notification of any admission due to Medical Emergency.

UMR Care Management is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

Schedule of Basic Medical Expense Benefits

Injury and Sickness

**Up to \$75,000 Maximum Lifetime Benefit Paid as Specified Below
(For Each Injury or Sickness)**

Deductible \$200 (Per Insured Person, Per Policy Year)

Inpatient Deductible \$250 (Per Insured Person, Per Policy Year)

The Preferred Provider for this plan UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network Provider is used.

There is an additional \$250 (Per Policy Year) Inpatient Deductible. This is in addition to the \$200 (Per Policy Year) Deductible.

Preferred Provider/Out-of-Network Provider benefits do not apply to Accidental Death and Dismemberment, Outpatient Physiotherapy, Prescription Drugs and Dental. See below for individual benefit maximums.

The exclusion for sleep disorders will be waived and benefits will be paid as any other Sickness for expenses due to sleep apnea.

SHC Benefits: Covered Medical Expenses will be paid at 100% at the Student Health Center. Prescription Drugs are covered after a \$5 copay per prescription for generic/\$15 copay per prescription for brand, up to a 31-day supply per prescription. Benefits for laboratory service will be payable after a \$10 copayment.

NOTE: Out-of-country claims will be paid at 80% of Allowable Charges.

All benefit maximums are combined Preferred Provider and Out-of-Network, unless noted below. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:

**PA = Preferred Allowance / U&C = Usual & Customary Charges /
AC = Allowable Charges**

| INPATIENT | PREFERRED PROVIDER | OUT-OF-NETWORK |
|--|--------------------|----------------|
| Room & Board Expenses , daily semi-private room rate; and general nursing care provided by the Hospital. | 80% of PA | 50% of AC |
| Intensive Care | 80% of PA | 50% of AC |
| Hospital Miscellaneous Expenses , such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. | 80% of PA | 50% of AC |

| INPATIENT | PREFERRED PROVIDER | OUT-OF-NETWORK |
|--|---|----------------|
| Routine Newborn Care , 4 days Hospital Confinement expense maximum, while Hospital Confined; and routine nursery care provided immediately after birth. | Paid as any other Sickness | |
| Physiotherapy | 80% of PA | 50% of AC |
| Surgeon's Fees , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | 80% of PA | 50% of AC |
| Anesthetist , professional services in connection with inpatient surgery. | 80% of PA | 80% of AC |
| Registered Nurse's Services , private duty nursing care. | 80% of PA | 50% of AC |
| Physician's Visits , benefits are limited to one visit per day. | 80% of PA | 50% of AC |
| Pre-Admission Testing , payable within 3 working days prior to admission. | 80% of PA | 50% of AC |
| Mental Illness/Substance Abuse , benefits are limited to one visit per day. Includes treatment for anorexia and bulimia. | See Benefits for Mental Illness / Substance Abuse | |
| Biologically Based Mental Illness | Paid as any other Sickness. See Benefits for Biologically Based Mental Illness | |
| OUTPATIENT | PREFERRED PROVIDER | OUT-OF-NETWORK |
| Surgeon's Fees , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | 80% of PA | 50% of AC |
| Day Surgery Miscellaneous , related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index. | 80% of PA | 50% of AC |

| OUTPATIENT | PREFERRED PROVIDER | OUT-OF-NETWORK |
|--|-----------------------------------|--|
| Anesthetist , professional services administered in connection with outpatient surgery. | 80% of PA | 80% of AC |
| Physician's Visits , benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to Physiotherapy. <i>(The copay/Deductible are in lieu of the Policy Deductible. No copay/Deductible at the Student Health Center.)</i> | 100% of PA / \$30 copay per visit | 70% of AC / \$30 Deductible per visit |
| Medical Emergency Expenses , use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. The copay/Deductible are in addition to the policy Deductible. | 100% of PA / \$75 copay per visit | 100% of AC / \$75 Deductible per visit |
| Diagnostic X-ray & Laboratory Services | 80% of PA | 50% of AC |
| Chemotherapy & Radiation Therapy | 80% of PA | 50% of AC |
| Injections , when administered in the Physician's office and charged on the Physician's statement. Injections for allergy will be covered at 100% when administered at the Student Health Center. | 80% of PA | 50% of AC |
| Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. | 80% of PA | 50% of AC |
| Physiotherapy , benefits are limited to one visit per day. Benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the Attending Physician's release for rehabilitation. Spinal manipulations benefit is limited to \$500 Per Policy Year. Physiotherapy limitations will not apply with a Student Health Center referral. <i>(Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.)</i> | 80% of PA | 80% of U&C |

| OUTPATIENT | PREFERRED PROVIDER | OUT-OF-NETWORK |
|---|--|---|
| Prescription Drugs, \$1,200 maximum Per Policy Year. Includes contraceptives. (Mail order Prescription Drugs through UHPS at 2.5 times the retail copay up to a 90 day supply subject to the prescription drug benefit maximum.) | UnitedHealthcare Network Pharmacy (UHPS) \$15 copay per prescription for Tier 1 \$30 copay per prescription for Tier 2 \$50 copay per prescription for Tier 3 up to a 31-day supply per prescription | No Benefits. Prescriptions must be filled at the SHC or a participating UnitedHealthcare Network Pharmacy |
| Mental Illness/Substance Abuse , including all related and ancillary charges incurred as a result of a Mental and Nervous Disorder. Benefits are limited to one visit per day. Includes treatment for anorexia and bulimia. | See Benefits for Mental Illness / Substance Abuse | |
| Biologically Based Mental Illness | Paid as any other Sickness / See Benefits for Biologically Based Mental Illness | |
| OTHER | | |
| Ambulance Services | 80% of PA | 80% of U&C |
| Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered. | 80% of PA | 80% of U&C |
| Consultant Physician Fees , when requested and approved by the attending Physician. | 80% of PA | 50% of AC |
| Dental Treatment, \$500 maximum per Injury , made necessary by Injury to Sound, Natural Teeth. | 80% of U&C | 80% of U&C |
| Maternity & Complications of Pregnancy | Paid as any other Sickness | |
| Allergy Testing, Includes allergy serums. | 80% of PA | 50% of AC |
| Home Health Care, 60 visits max per Policy Year. | 80% of PA | 50% of AC |

Basic Medical Expense Benefits - Maximum Lifetime Benefit

Amounts paid to the Insured under this policy, and under all prior years' policies for any one Injury or Sickness, will be considered payments accrued under the Maximum Lifetime Benefit. The Maximum Lifetime Benefit will not exceed an amount determined by subtracting from \$75,000 all amounts paid to the Insured under any student injury and sickness policy issued to the college for any one Injury or Sickness.

UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable copayments. Your copayment is determined by the tier to which the Prescription Drug is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com/wm or call 877-417-7345 for the most up-to-date tier status.

\$15 copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31-day supply

\$30 copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31-day supply

\$50 copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31-day supply

Mail order prescription drugs are available at 2.5 times the retail copay up to a 90 day supply.

Your maximum allowed benefit is \$1,200 per policy year.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription. However, if a non-Network pharmacy has entered into an agreement with us that it agrees to accept the same terms and conditions applicable to Network Pharmacies, including reimbursement at the rate applicable to the Network Pharmacies, including applicable copayment, as payment in full, you may receive benefits on the same basis and at the same copayment as you would from a Network Pharmacy.

If you do not present the card, you will need to pay the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com/wm and log in to your online account or call 877-417-7345.

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.

4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician.
Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

Definitions

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com/wm or call Customer Service at 1-877-417-7345.

Preferred Provider Information

“Preferred Providers” are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

UnitedHealthcare Options PPO

The availability of specific providers is subject to change without notice. Insured's should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700, and/or by asking the provider when you make an appointment for services.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

“Allowable Charges” means the Company's allowance for a specified Covered Medical Expense or the Provider's charge for the service, whichever is less.

“Out of Network” providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

“Network Area” means the 10 mile radius around the local school campus the Named Insured is attending.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Medical Expense Benefits.

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be covered at the coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call 1-800-767-0700 for information about Preferred Hospitals.

OUT-OF-NETWORK HOSPITALS - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Options PPO will be paid at the coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Optional Major Medical Benefit

\$125,000 Maximum Benefit (For each Injury or Sickness) or

\$175,000 Maximum Benefit (For Each Injury or Sickness)

This optional benefit is subject to payment of an additional premium as specified on the enrollment card. Optional benefits may only be purchased at the time of initial enrollment in the Plan and may not be added later.

The Major Medical Benefit begins payment after the Basic Maximum Benefit of **\$75,000** has been paid by the Company. The Company will pay 100% for additional Covered Medical Expenses incurred up to the Major Medical Maximum of **\$125,000**. The total benefit payable under Major Medical is **\$200,000** minus the Basic Benefits already paid.

OR

The Major Medical Benefit begins payment after the Basic Maximum Benefit of **\$75,000** has been paid by the Company. The Company will pay 100% for additional Covered Medical Expenses incurred up to the Major Medical Maximum of **\$175,000**. The total benefit payable under Major Medical is **\$250,000** minus the Basic Benefits already paid.

No benefits will be paid under Major Medical for:

- 1) Room & Board expenses which exceed the semi-private room rate;
- 2) Dental treatment;
- 3) Mental Illness/Substance abuse in excess of the minimum mandated benefits specified in the Benefits for Mental Illness/Substance Abuse;
- 4) Outpatient Physiotherapy; and
- 5) Pre-existing Conditions for a period of 6 months except for individuals who have been continuously insured under the school's Optional Major Medical coverage for at least 6 months. If an individual: (1) had coverage under Creditable Coverage as defined and (2) that coverage was continuous to a date not more than 63 days prior to the Insured's Effective Date under this Optional Major Medical coverage, the time under the previous plan will be credited toward the 6 consecutive months needed to provide benefits for a Pre-existing Condition.

Pre-existing Condition limitations will not apply: a) for individuals who, as of the last day of the thirty-day period beginning under the date of birth, are covered under Creditable Coverage; b) any child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage; or c) to pregnancy.

Maternity Testing

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered if all other policy provisions have been met: **Initial screening at first visit** – Pregnancy test: Urine human chorionic gonatropin (HCG), Asymptomatic bacteriuria: Urine culture, Blood type and Rh antibody, Rubella, Pregnancy-associated plasma protein-A (PAPPA) (first trimester only), Free beta human chorionic gonadotrophin (hCG) (first trimester only), Hepatitis B: HBsAg, Pap smear, Gonorrhea: Gc culture, Chlamydia: chlamydia culture, Syphilis: RPR, HIV: HIV-ab; and Coombs test; **Each visit** – Urine analysis; **Once every trimester** – Hematocrit and Hemoglobin; **Once during first trimester** – Ultrasound; **Once during second trimester** – Ultrasound (anatomy scan); Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a; **Once during second trimester if age 35 or over** - Amniocentesis or Chorionic villus sampling (CVS); **Once during second or third trimester** – 50g Glucola (blood glucose 1 hour postprandial); and **Once during third trimester** - Group B Strep Culture. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

Accidental Death And Dismemberment Benefits

Loss of Life, Limb or Sight:

If such Injury shall, independently of all other causes and within 180 days from the date of Injury, solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below. Payment under this benefit will not exceed the Policy Maximum Benefit.

For Loss Of:

| | |
|---------------------|---------|
| Life | \$1,000 |
| Two or More Members | \$1,000 |
| One Member | \$ 500 |

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 90 days and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 180 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

Application must be made and premium must be paid directly to UnitedHealthcare **Student Resources** and be received within 31 days after the expiration date of your student coverage. For further information on the Continuation privilege, please contact UnitedHealthcare **StudentResources** at 1-800-767-0700.

Excess Provision

Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other group insurance.

Benefits will be paid on the unpaid balances after your other group insurance has paid. No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible group insurance. This Excess Provision will not be applied to any claim against or settlement with a third person responsible for such personal Injury.

However, this Excess Provision will not be applied to the first \$100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other group insurance does not cover the loss.

Mandated Benefits

Benefits for Pregnancy from Rape or Incest

Benefits will be paid as for any other Injury for pregnancy resulting from an act of rape or incest which was reported to the police within 7 days, or 180 days if under 13 years of age, following the incident.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Mammography

Benefits will be paid the same as any other Sickness for low-dose screening Mammograms for determining the presence of occult breast cancer according to the following guidelines:

1. One screening Mammogram to persons age thirty-five through thirty-nine.
2. One Mammogram biennially to persons age forty through forty-nine.
3. One Mammogram annually to persons age fifty and over.

Benefits shall not exceed a maximum of \$50 per Mammogram.

"Mammogram" shall mean 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. The equipment used to perform the mammogram must meet the radiation protection regulations standards set forth by the Virginia Department of Health.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Pap Smears

Benefits will be paid the same as any other Sickness for an annual pap smear performed by any FDA approved gynecologic cytology screening technologies.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

***Benefits for Reconstructive Breast
Surgery Following Mastectomy***

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery. The reimbursement for Reconstructive Breast Surgery will be determined according to the same formula by which charges are developed for other medical and surgical procedures.

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

"Reconstructive breast surgery" means surgery performed (1) coincident with or following a Mastectomy or (2) following a Mastectomy to reestablish symmetry between the two breasts, Reconstructive Breast Surgery performed on or after October 21, 1998, and while the Insured is or was covered under the policy. Reconstructive breast surgery shall also include coverage for prostheses, determined as necessary in consultation with the attending Physician and Insured, and physical complications of Mastectomy, including medically necessary treatment of lymphedemas.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Hysterectomy

Benefits will be paid the same as any other Sickness for a minimum of 23 hours Hospital stay for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. Nothing in this section shall be construed as requiring the total hours referenced when the attending Physician in consultation with the patient determines that a shorter period of Hospital stay is appropriate.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Prostate Cancer Screening

Benefits will be paid the same as any other Sickness (1) for Insureds age fifty and over and (2) for Insureds age forty and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Colorectal Cancer Screening

Benefits will be paid the same as any other Sickness for colorectal cancer screening. Coverage shall include an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or, in appropriate circumstances, radiologic imaging shall be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Inpatient Coverage Following Mastectomy

Benefits will be paid the same as any other Sickness for a minimum of 48 hours of inpatient care following a radical or modified radical mastectomy and a minimum of 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where the attending Physician in consultation with the patient determines that a shorter period of Hospital stay is appropriate.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Diabetes

Benefits will be paid for diabetes equipment and supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

As provided in the benefit, diabetes equipment and supplies shall not be considered Durable Medical Equipment under this policy.

Benefits shall only be subject to any Deductible, copayment and coinsurance provisions of the policy.

Benefits for Hospice Care

Benefits will be paid the same as any other Sickness for Hospice Services.

"Hospice services" shall mean a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed under Article 7 (32.1-162.1 et seq.) of Chapter 5 of Title 32.1, and shall include palliative 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" shall mean 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 rather than curative care. "Palliative care" shall mean 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.

Documentation requirements shall be no greater than those required for the same service under Medicare.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Prescriptions for Cancer Pain in Excess of Recommended Dosage

Benefits will be paid the same as any other Sickness for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer pain. Benefits will not be denied on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia Statutes 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Mental Illness and Substance Abuse

Benefits will be paid the same as any other Sickness for inpatient and partial hospitalization for mental illness and substance abuse services as follows:

- 1) Treatment for 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 twenty (20) days per policy year.
- 2) Treatment for 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 period of twenty-five (25) days per policy year.
- 3) Up to ten (10) days of the inpatient benefit set forth in (1) and (2) may be converted when medically necessary at the option of the person or the parent, as defined in Virginia Statute 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage.

Benefits will be paid the same as any other Sickness for outpatient mental illness and substance abuse services as follows:

- 1) A minimum of twenty (20) visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy year.
- 2) The limits of the benefits shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy year will be paid at 50% of Usual and Customary Charges.
- 3) Medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit.
- 4) If all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any Deductible required by the policy, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Biologically Based Mental Illness

Benefits will be paid the same 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 Insured's functioning.

The following diagnoses are defined as Biologically Based Mental Illness as they apply to adults and children:

1. schizophrenia;
2. schizoaffective disorder;
3. bipolar disorder;
4. major depressive disorder;
5. panic disorder;
6. obsessive-compulsive disorder;
7. attention deficit hyperactivity disorder;
8. autism; or
9. drug and alcohol addiction.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Home Treatment of Hemophilia and Congenital Bleeding Disorders

Benefits will be paid the same as any other Sickness for the Home Treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Benefits include coverage for 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 treatment center.

"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 received 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.

"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.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

***Benefits for Treatments Involving Bones
and Joints of the Head, Neck, Face or Jaw***

Benefits will be paid for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw the same as for the diagnosis and treatment to any bone or joint of the skeletal structure. Such treatment must be required because of a Sickness or Injury which prevents normal function of the joint or bone and be deemed a Medical Necessity to attain functional capacity of the affected part.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

***Benefits for Clinical Trials for
Treatment Studies on Cancer***

Benefits will be paid the same as any other Sickness for Patient Costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

"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 Insured for purposes of a clinical trial. Patient cost does not include (1) 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, (2) costs associated with managing the research associated with the clinical trial, or (3) the cost of the investigational drug or device.

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 be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial. The treatment shall be provided by a clinical trial approved by:

- (1) The National Cancer Institute (NCI);
- (2) An NCI cooperative group or an NCI center;
- (3) The Federal Food and Drug Administration (FDA) in the form of an investigational new drug application;
- (4) The federal Department of Veterans Affairs; or
- (5) An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

This benefit shall apply only if:

- (1) There is no clearly superior, noninvestigational treatment alternative;
- (2) The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and
- (3) The Insured and the Physician or health care provider who provides services to the Insured conclude that the Insured's participation in the clinical trial would be appropriate, pursuant to procedures established by the Company, as disclosed in the policy and evidence of coverage.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

***Benefits for General Anesthesia and
Hospitalization for Dental Care***

Benefits will be paid the same as any other Sickness for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to an Insured who is determined by a licensed dentist in consultation with the Insured's treating Physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care and (a) is under the age of five, or (b) is severely disabled, or (c) has a medical condition and requires admission to a Hospital or outpatient surgery facility for dental care treatment.

For purposes of this provision, a determination of Medical Necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the Insured requires the utilization of general anesthesia and the admission to a Hospital or outpatient surgery facility to safely provide the underlying dental care.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Early Intervention Services

Benefits will be paid the same as any other Sickness for medically necessary Early Intervention Services. Such coverage shall be limited to a benefit of \$5,000 per Insured per policy year. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the Company to or on behalf of the Insured during the Insured's lifetime.

"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 Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act. These services are 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.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy except any lifetime provision.

Benefits for Newborn Infant Hearing Screening

Benefits will be paid the same as any other Sickness for newborn infant hearing screenings and all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recommended by the National Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such benefits shall include any 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 shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

***Benefits for Prescription Drugs for Cancer Treatment
and Treatment of a Covered Indication***

Benefits will be paid for Prescription Drugs, including all services that are a Medical Necessity associated with the administration of the drug, to treat cancer subject to the following provisions.

Benefits will not be denied for any drug approved by the United States Food and Drug Administration (FDA) for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia.

Benefits will not be denied for any drug prescribed to treat a covered indication so long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-reviewed Medical Literature.

"Standard reference compendia" means the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; or the United States Pharmacopoeia Dispensing Information.

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

This provision shall not be construed to do any of the following:

1. Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the specific type of cancer or indication for which the drug has been prescribed;
2. Require coverage for any experimental drug not otherwise approved for any indication by the FDA;
3. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA; or
4. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Childhood Immunizations

Benefits will be paid the same as any other Sickness for childhood immunizations for Dependent children from birth to thirty-six months. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other immunizations as may be prescribed by the Commissioner of Health.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Treatment of Morbid Obesity

Benefits will be paid the same as any other Sickness for the treatment of Morbid Obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for long-term reversal of Morbid Obesity. For the purpose of this provision, "morbid obesity" means (a) 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, (b) 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 (c) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Definitions

ADOPTED OR NEWBORN CHILD means 1) a newly born child of the Insured from the moment of birth provided that person is insured under this policy; 2) a child adopted by the Insured provided the person adopting the child is insured under this policy on the date the adoption becomes effective; and 3) a child who has been placed for adoption with the Insured provided the person adopting the child is insured under the policy on the date the child is placed with the Insured. Such child will be covered under the policy for the first 31 days after: 1) birth of the newly born child; 2) the effective date of adoption of the child; and 3) the date of placement of the child for adoption, unless the placement is disrupted prior to final decree of adoption, and the child is removed from placement with the Insured. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity, nursery care; inpatient and outpatient dental, oral surgical, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia. Benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the date of birth, adoption, or placement for adoption: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the date of birth, adoption, or placement for adoption.

COMPLICATION OF PREGNANCY means a condition 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy. The term "complication of pregnancy" includes non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; hyperemesis gravidarum; and, pre-eclampsia.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

CREDITABLE COVERAGE means (1) a group health plan; (2) health insurance; (3) Medicare or Medicaid; (4) an employer-based health insurance or benefit plan with similar benefits to this policy; (5) an individual policy; health maintenance organization; Multiple Employer Welfare Arrangement; fraternal benefit society; nonprofit medical and surgical plan or hospital service plan that provides similar benefits to this policy; or an employee benefit plan subject to ERISA; (6) Armed Forces Personnel Medical and Dental Care; (7) Indian Health Service or tribal medical care program; (8) a state health benefits risk pool; (9) Federal Employees Health Benefit Plan; (10) a public health plan; (11) the Peace Corps Act health benefit plan; (12) church plan; or (13) college plan.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

DEPENDENT means the spouse (husband or wife) of the Named Insured and their dependent, unmarried children and children that the Insured must provide coverage due to court order. Children shall cease to be dependent on the first to occur of:

- 1) The end of the month in which they marry; or
- 2) The end of the month in which they attain the age of nineteen (19) years; or (25) years, if a full-time dependent student at an accredited institution of higher learning. A dependent child enrolled as a full-time student who is unable to continue as a full-time student due to a medical condition will continue to remain dependent for a period of not more than 12 months from the date the dependent child ceases to be a full-time student, or until the dependent child attains age 25, whichever occurs first, provided the dependent child's Physician certifies to the Company at the time the dependent child withdraws as a full-time student that the dependent child's absence is a Medical Necessity.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

- 1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- 2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

For the treatment of Mental and Nervous Disorder/Alcohol and Drug Dependence, Hospital also means a licensed alcohol or drug rehabilitation facility, intermediate care facility, and mental health treatment facility. These facilities are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

INSURED PERSON means 1) the Named Insured; and 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term "Insured" also means Insured Person.

INTENSIVE CARE means 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

- 1) Progressive care;
- 2) Sub-acute intensive care;
- 3) Intermediate care units;
- 4) Private monitored rooms;
- 5) Observation units; or
- 6) Other facilities which do not meet the standards for intensive care.

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:

- 1) Death;
- 2) Placement of the Insured's health in jeopardy;
- 3) Serious impairment of bodily functions;
- 4) Serious dysfunction of any body organ or part; or
- 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "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.

MEDICAL NECESSITY means those services or supplies provided or prescribed by a Hospital or Physician which are:

- 1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
- 2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury;
- 3) In accordance with the standards of good medical practice;
- 4) Not primarily for the convenience of the Insured, or the Insured's Physician; and
- 5) The most appropriate supply or level of service which can safely be provided to the Insured

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which in the judgment of the Company are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

MENTAL AND NERVOUS DISORDER means a Sickness that is a mental, emotional or behavioral disorder. Mental and Nervous Disorder does not mean a Mental Illness as defined in the Benefits for Biologically Based Mental Illness. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the (International Classification of Diseases) are considered one Sickness.

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture; pathology; or disease.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POSITIVE X-RAY means an X-ray that shows the presence of a fracture; pathology; or disease.

PRE-EXISTING CONDITION means any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months immediately prior to the Insured's Effective Date under this policy.

PRESCRIPTION DRUGS means 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

PSYCHOTHERAPY means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions And Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Acupuncture;
2. Assistant Surgeon Fees;
3. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or intellectual disability, except as specifically provided in the policy;
4. Circumcision;
5. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
6. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
7. Dental treatment; except for accidental Injury to Sound, Natural Teeth;
8. Elective Surgery or Elective Treatment;
9. Elective abortion;

10. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when apart from the disease process;
11. Foot care including flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet;
12. Hearing examinations or hearing aids; or other treatment for hearing defects and problems; except as provided in Benefits for Newborn Infant Hearing Screening. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
13. Hirsutism; alopecia;
14. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
15. Injury caused by, contributed to, or resulting from the use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
17. Injury sustained while (a) participating in any interscholastic, intercollegiate, or professional sport, contest or competition; (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;
18. Lipectomy;
19. Organ transplants;
20. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
21. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;
22. Pre-existing Conditions for a period of 6 months; except for individuals who have been continuously insured under the school's student insurance policy for at least 6 months. If an individual: (1) had coverage under Creditable Coverage as defined and (2) that coverage was continuous to a date not more than 63 days prior to the Insured's Effective Date under this policy, the time under the previous plan will be credited toward the 6 consecutive months needed to provide benefits for a Pre-existing Condition.
Pre-existing Condition limitations will not apply:
 - a) for individuals who, as of the last day of the thirty-day period beginning under the date of birth, are covered under Creditable Coverage;
 - b) any child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage; or
 - c) to pregnancy;

23. Prescription Drugs, services or supplies as follows:
 - a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
 - b. Immunization agents, biological sera, blood or blood products administered on an outpatient basis; except as specifically provided in the Benefits for Home Treatment of Hemophilia and Congenital Bleeding Disorders;
 - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - d. Products used for cosmetic purposes;
 - e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
 - f. Anorectics - drugs used for the purpose of weight control;
 - g. Fertility agents, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene;
 - h. Growth hormones; or
 - i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
24. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
25. Routine Newborn Infant care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
26. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the Policy;
27. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
28. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
29. Sleep disorders;
30. Supplies, except as specifically provided in the Policy;
31. Surgical breast reduction, breast augmentation, breast implants, breast prosthetic devices; or gynecomastia, except as specifically provided by the Policy;
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
33. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
34. Weight management, weight reduction, nutrition programs, treatment for obesity, (except morbid obesity) surgery for removal of excess skin or fat.

Scholastic Emergency Services: Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you and your insured spouse and minor child(ren) are eligible for Scholastic Emergency Services (SES). The requirements to receive these services are as follows:

International Students, insured spouse and insured minor child(ren): You are eligible to receive SES worldwide, except in your home country.

Domestic Students, insured spouse and insured minor child(ren): You are eligible for SES when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

SES includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, Inc.; any services not arranged by SES, Inc. will not be considered for payment.

Key Services include:

- * Medical Consultation, Evaluation and Referrals
- * Foreign Hospital Admission Guarantee
- * Emergency Medical Evacuation
- * Medically Supervised Repatriation
- * Emergency Counseling Services
- * Lost Luggage or Document Assistance
- * Care for Minor Children Left Unattended Due to a Medical Incident
- * Prescription Assistance
- * Critical Care Monitoring
- * Return of Mortal Remains
- * Transportation to Join Patient
- * Interpreter and Legal Referrals

Please visit your school's insurance coverage page at www.uhcsr.com for the SES Global Emergency Assistance Services brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States

(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

When calling the SES Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached.

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at www.uhcsr.com for additional information, including limitations and exclusions pertaining to the SES program.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

Complaint Resolution

Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 800-767-0700. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

Notice: Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason, please contact the insurance company issuing this insurance at the address and telephone number listed in the Claim Procedure section on the following page. If you have been unable to contact or obtain satisfaction from the insurance company, you may contact:

Virginia State Corporation Commission
Life and Health Division
Bureau of Insurance
P. O. Box 1157
Richmond, Virginia 23218
Telephone: 1-804-371-9691
Fax: 1-804-371-9944
or
1-800-522-7945 (In-State Only)
1-877-310-6560 (National)

General Provisions

The policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change the policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

A copy of any application of the Policyholder shall be attached to the policy when issued. All statements made by the Policyholder or Insured Person shall be deemed representations and not warranties. No written statement made by any Insured Person shall be used in any contest unless a copy of the statement is furnished to the Insured or to his beneficiary or personal representative.

The validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. The Company reserves the right to contest the validity of the policy for up to two years from its date of issue. No statement made by any person insured under the policy relating to his insurability or the insurability of his insured Dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1) after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2) unless the statement is contained in a written instrument signed by him. This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law.

The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

Indemnities payable under this policy for any loss will be paid within 60 days after receipt of due written proof of such loss.

All benefits are payable to the Insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parents, guardian, or other person actually supporting him. Subject to any written direction of the Insured, all or a portion of any benefits payable under this policy may be paid directly to the Hospital, Physician or person rendering the service or treatment. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

Frequently Asked Questions

1) What are the changes from last years policy to the new 2011-2012 policy?

1. Waived Deductible for Outpatient Physician's Visits.
2. Outpatient Physiotherapy; added "medical necessity" wording: (Review of Medical Necessity will be performed after 12 visits per Injury or Sickness).
3. Removed Hyperkinetic Syndromes from exclusion #3.

2) I need to see a doctor, do I need a referral and can I see any physician?

If you live within 10 miles from campus, you must see the Student Health Center for a referral prior to seeing your physician, unless one of the following apply: 1) it is a medical emergency; 2) the Student Health Center is closed or you are on vacation. You may choose to see any health care provider with this plan. However, to receive the highest levels of coverage we encourage you to use a preferred provider under the UnitedHealthcare Options PPO.

3) What if there is no UnitedHealthcare Options PPO provider in my area, I am out of state or traveling abroad?

If a preferred provider is not available in the network area, benefits will be paid at the level of benefits shown as in-network benefits.

Out-of-country claims will be paid at 80% of Allowable Charges.

4) I gave my doctor the temporary ID card and they would not accept it. What should I do?

Have the health care provider call 1-800-767-0700 or the number on your I.D. Card for verification of coverage and benefits. This is an acceptable card and should not be refused by the health care provider. The provider may be telling you that they do not participate as a UnitedHealthcare Options PPO preferred provider, but this does not mean they will not see you as a patient or file the insurance for you.

5) What is the Deductible?

\$200 Per Insured Person, Per Policy Year, an additional \$250 Inpatient Deductible Per Insured Person, Per Policy Year, and an additional \$75 copay/Deductible for each Emergency Room visit.

The first \$200 of incurred covered medical expenses, that would otherwise be paid by the insurance company, is paid by you. Be sure that the insurance company receives receipts for all costs you incur so these expenses can be allocated towards meeting your deductible.

6) How do I get reimbursed for a prescription?

See the UnitedHealthcare Network Pharmacy Benefits section on page 8 for complete information on using the UnitedHealthcare Network Pharmacy Benefit.

7) What does this plan cover?

Please read the enclosed brochure for a complete summary of your benefits and for limitations on the coverage and on the schedule of benefits.

8) What is NOT COVERED on this plan?

Please read the additional Exclusions and Limitations carefully in this brochure and on the schedule of benefits.

9) How do I file a claim and who do I call with claim questions?

The UnitedHealthcare Options PPO providers and most hospitals and physicians will bill us directly for reimbursement, then bill you for any unpaid balance. If a provider wants you to pay for the charges up front, please send the complete itemized bill to UnitedHealthcare StudentResources, P.O. Box 809025, Dallas, Texas 75380-9025 for reimbursement. You do not need to complete a claim form when filing a claim. Please call 1-800-767-0700 for claim questions and inquiries.

10) Will this plan cover my pre-existing condition?

No benefits will be paid for Pre-existing Conditions for a period of 6 months; except for individuals who have been continuously insured under the school's student insurance policy for at least 6 months. If an individual: (1) had coverage under Creditable Coverage as defined and (2) that coverage was continuous to a date not more than 63 days prior to the Insured's Effective Date under this policy, the time under the previous plan will be credited toward the 6 consecutive months needed to provide benefits for a Pre-existing Condition.

Pre-existing Condition limitations will not apply:

- a) for individuals who, as of the last day of the thirty-day period beginning under the date of birth, are covered under Creditable Coverage;
- b) any child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage; or
- c) to pregnancy.

Claim Procedure

In the event of Injury or Sickness, students should:

- 1) Report to the Student Health Center or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
- 2) Provide written notice of claim to the Company within 90 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company with information sufficient to identify the Named Insured shall be deemed notice to the Company.
- 3) Claim forms are not required. Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, social security number and name of the College under which the student is insured.
- 4) File claim within 90 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year from the time proof is otherwise required will not be considered for payment except in the absence of legal capacity.

The Plan Is Underwritten by:
UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700
customerservice@uhcsr.com
claims@uhcsr.com

Online Services: Please visit our website at www.uhcsr.com/wm for Certificates, Enrollment Cards (printable using Adobe Acrobat), coverage receipts, ID cards, claims status and other services.

Please keep this Certificate as a general summary of the insurance. 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 in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

This Certificate is based on Policy #2011-1404-2

v3-NOC 1 (11/04/2011)



POLICY NUMBER: 2011-1404-2

NOTICE:

The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC 1 (11/04/2011)

- Outpatient Physician's Visits – Change parenthetical:

FROM: (Benefits for Physician's visits do not apply when related to surgery or Physiotherapy)

TO: (Benefits for Physician's visits do not apply when related to Physiotherapy)