

READ YOUR CERTIFICATE CAREFULLY

2011-2012

STUDENT
INJURY AND SICKNESS
INSURANCE PLAN

NON-RENEWABLE ONE YEAR TERM INSURANCE
BLANKET ACCIDENT AND HEALTH POLICY

DESIGNED ESPECIALLY FOR THE STUDENTS OF

REFORMED
THEOLOGICAL
SEMINARY



PRE-EXISTING CONDITION EXCLUSION

Conditions diagnosed, treated or recommended for treatment within the 12 months prior to the Insured's effective date under the policy may not be covered immediately.



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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 1-800-767-0700 or by visiting us at www.uhcsr.com.

Eligibility

All full-time registered students are required to purchase this insurance Plan, unless proof of comparable coverage is furnished. All part-time registered students are eligible to enroll in this insurance Plan.

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 Eligibility or 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 who are not self-supporting. Dependent Eligibility is effective and expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 24, 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 11:59p.m., August 23, 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.

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.

If paying premiums by semi-annual, coverage expires as follows:

North Carolina Campus

Annual

08-24-11 to 08-23-12

First Semi Annual

08-24-11 to 01-30-12

Second Semi Annual

01-31-12 to 08-23-12

Premium Rates

	<u>Annual</u>	<u>First Semi-Annual</u>	<u>Second Semi Annual</u>
Full Time			
Student:	\$ 916.00	\$ 467.00	\$ 467.00
Spouse:	\$2012.00	\$1026.00	\$1026.00
Each Child:	\$ 1149.00	\$ 586.00	\$ 586.00
Part Time			
Student:	\$ 916.00	\$ 467.00	\$ 467.00
Spouse:	\$1992.00	\$1016.00	\$1016.00
Each Child:	\$ 1140.00	\$ 581.00	\$ 581.00

Note: Reformed Theological Seminary and The William Morris Group, P.A. have no obligation or liability for payment of health insurance benefits under the 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 long as the condition continues but not to exceed 90 days 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.

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

Up To \$2,500 Maximum Benefit Paid as Specified Below For Each Injury
 Up To \$2,500 Maximum Benefit Paid as Specified Below For Each Sickness
 Injury Only: Deductible \$500 (Per Insured Person) (For Each injury)
 Sickness Only: Deductible \$25 (Per Insured Person) (For Each Sickness)

Full-time Students and their Dependents: Covered Medical Expenses will be paid at 80% for Injury and 100% for Sickness up to \$2,500 after the Deductible has been satisfied, under the Basic Medical Expense benefits except as specified below. After the Company has paid \$2,500, benefits will be paid at 80% of additional, incurred Covered Medical Expenses for both Injury and Sickness up to the Major Medical Maximum Benefit of \$22,500. After the Company has paid \$25,000 under Major Medical, benefits will be paid under Catastrophic Medical Expenses at 100% of incurred Covered Medical Expenses for both Injury and Sickness in an amount not to exceed a total Maximum Benefit of \$100,000 for each Injury and Sickness.

Part time Students and their Dependents: Covered Medical Expenses will be paid at 80% for Injury and 100% for Sickness up to \$2,500 after the Deductible has been satisfied, under the Basic Medical Expense benefits. After the Company has paid \$2,500, benefits will be paid at 80% of additional, incurred Covered Medical Expenses for both Injury and Sickness up to the Major Medical Maximum Benefit of \$17,500 not to exceed a total Maximum Benefit of \$20,000 for each Injury and Sickness.

The Policy provides benefits for the Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:

U&C = Usual & Customary Charges

INPATIENT	Injury Only	Sickness Only
Room and Board Expense , daily semi-private room rate and general nursing care provided by the Hospital.	U&C	\$350 per day / 30 days maximum
Intensive Care	Paid under Room & Board Expense	
Routine Newborn Care , while hospital confined, and routine nursery care provided immediately after birth.	No Benefits	Paid as any other Sickness/ 48 hours vaginal / 96 hours cesarean Hospital Confinement expense maximum
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.	U&C	\$900 the first day / \$500 each subsequent day
Physiotherapy	U&C	\$10 per day / \$100 maximum

INPATIENT (Continued)	Injury Only	Sickness Only
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.	U&C	80% of Usual and Customary Charges/ \$2,000 maximum
Assistant Surgeon	No Benefits	20% of Surgery Allowance
Anesthetist , professional services in connection with inpatient surgery.	U&C	25% of Surgery Allowance
Registered Nurse's Services , private duty nursing care.	U&C	\$100 per day
Physician's Visits , benefits are limited to one visit per day and do not apply when related to surgery.	U&C	\$35 per day
Pre-Admission Testing , this benefit is payable within 3 working days prior to admission.	U&C	Paid under Hospital Misc. Expenses
Psychotherapy , Psychiatric Hospitals are not covered. Benefits are limited to one visit per day.	No Benefits	Paid as any other Sickness
OUTPATIENT		
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.	U&C	80% of Usual and Customary Charges/ \$2,000 maximum
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.	U&C	\$750 maximum
Assistant Surgeon	No Benefits	20% of Surgery Allowance
Anesthetist , professional services administered in connection with outpatient surgery.	U&C	25% of Surgery Allowance
Physician's Visits , benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to Surgery or Physiotherapy.	U&C	\$35 per day beginning with the 2nd visit / \$500 maximum
Physiotherapy , benefits are limited to one visit per day.	U&C	No Benefits

OUTPATIENT	Injury Only	Sickness Only
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.	U&C	\$250 maximum
Diagnostic X-ray & Laboratory Services	U&C	\$200 maximum
Radiation Therapy / Chemotherapy	No Benefits	
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	U&C	Paid under X-Rays & Laboratory
Injections , when administered in the Physician's office and charged on the Physician's statement.	U&C	No Benefits
Prescription Drugs	\$50 maximum	\$50 maximum
Psychotherapy , including all related or ancillary charges incurred as a result of a Mental and Nervous Disorder. Includes Prescription Drugs. (Benefits are limited to one visit per day.)	No Benefits	Paid as any other Sickness/ \$1,500 maximum
OTHER		
Ambulance Services	U&C	\$100 per trip / \$200 maximum
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	U&C	No Benefits
Consultant Physician Fees , when requested and approved by the attending Physician.	U&C	No Benefits
Dental Treatment , made necessary by Injury to Sound, Natural Teeth.	U&C / \$500 maximum	No Benefits
Alcoholism & Drug Abuse	No Benefits	\$1,000 maximum (Per Policy Year)
Maternity & Complications of Pregnancy	No Benefits	Paid as any other Sickness
TMJ Disorder , see benefits, page 8.	No Benefits	\$5,000 maximum (Per Policy Year)
Transportation of a Newborn , when the attending Physician certifies that it is necessary to protect the health and safety of the newborn.	No Benefits	\$1,000 maximum

Major Medical Benefit

Full-time Student & Dependents: \$22,500

Maximum Benefit For each Injury or Sickness

Part-time Student & Dependents: \$17,500 Maximum Benefit For each Injury or Sickness

The Major Medical Benefit begins payment after the Basic Maximum Benefit of \$2,500 has been paid by the Company.

The Company will pay 80% for additional Covered Medical Expenses incurred up to the Major Medical Maximum of \$22,500 for Full-time students and \$17,500 for Part-time students. The total benefit payable under Major Medical for Full-time students is \$25,000 and for Part-time students is \$20,000 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 for Injury only or \$350 per day/30 days maximum for Sickness only; 2) Dental treatment; 3) Prescription drugs; 4) Psychotherapy; 5) Outpatient Physiotherapy; and 6) Services designated as "No Benefits" in the Basic Medical Expense Benefits Schedule of Benefits.

Catastrophic Medical Benefit

Full-time Students and Their Insured Dependents Only

\$75,000 Maximum Benefit For each Injury or Sickness (Full-time Students & Insured Dependents Only)

After the Company has paid \$25,000 under the Basic and Major Medical Benefits the Company will pay 100% of additional Covered Medical Expenses incurred up to \$75,000.

The total benefit payable under Catastrophic Medical for any one Injury or Sickness is \$100,000 minus all amounts paid under the Basic and Major Medical Plan benefits.

No benefits will be paid under Catastrophic Medical for:

1) Room & Board expenses which exceed the semi-private room rate for Injury only or \$350 per day/30 days maximum for Sickness only; 2) Dental treatment; 3) Prescription drugs; 4) Psychotherapy; 5) Outpatient Physiotherapy; and 6) Services designated as "No Benefits" in the Basic Medical Expense Benefits Schedule of Benefits.

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 (Injury Only)

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	\$5,000
Two or More Members	\$5,000
One Member	\$2,500

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.

The accidental Death Benefit is payable for the involuntary inhalation of gas and fumes and the involuntary taking of poison.

Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than nine months 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. For payment of premium information please contact customer service at 1-800-767-0700.

Mandated Benefits

Benefits for Emergency Services

Benefits will be paid the same as any other Sickness or Injury for treatment of a Medical Emergency. The Insured should use emergency services, including calling 911 or other telephone access systems utilized to access prehospital emergency services when appropriate for treatment of a Medical Emergency.

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

Benefits for Temporomandibular Joint Disorder

Benefits will be paid the same as treatment to any other joint in the body for the treatment of Temporomandibular Joint Disorder ("TMJ"). Procedures will include splinting and use of intraoral prosthetic appliances to reposition the bones. Non-surgical treatment of TMJ is subject to a lifetime maximum benefit of \$3,500. No benefits will be paid for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, root canal or routine dental treatment.

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

Benefits for Surveillance Tests for Women at Risk for Ovarian Cancer

Benefits will be paid the same as any other Sickness for Surveillance Tests for women age 25 and older At Risk for Ovarian Cancer.

"At risk for ovarian cancer" means either 1) having family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or 2) testing positive for a hereditary ovarian cancer syndrome.

"Surveillance tests" mean annual screening using: 1) transvaginal ultrasound, and 2) rectovaginal pelvic examination.

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

Benefits for the Treatment of Lymphedema

Benefits will be paid the same as any other Sickness for the diagnosis, evaluation, and treatment of lymphedema including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a Physician.

Gradient Compression Garments:

1. require a prescription;
2. are custom-fit for the Insured Person; and
3. do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

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

Benefits for Cervical Cancer Screening

Benefits will be paid the same as any other Sickness for Examinations and Laboratory Tests for the screening for the early detection of cervical cancer. Benefits shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control and will include the examination, laboratory fee, and the Physician's interpretation of the laboratory results.

Reimbursement for the laboratory fee will be made only if the laboratory meets accreditation standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Examinations and laboratory tests" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

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

Benefits for Prostate-Specific Antigen (PSA) Test

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) or equivalent tests for the presence of prostate cancer when recommended by a Physician.

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 Mammography according to the following guidelines

1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this benefit, "at risk" means the following:
 - a. The woman has a personal history of breast cancer;
 - b. The woman has a personal history of biopsy-proven benign breast disease;
 - c. The woman's mother, sister, or daughter has or has had breast cancer; or
 - d. The woman has not given birth prior to the age of 30.
2. One baseline mammogram for any woman thirty-five through thirty-nine years of age, inclusive.
3. A mammogram every other year for any woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Physician.
4. A mammogram every year for any woman fifty years of age or older.

Reimbursement will be made only if the facility where treatment is rendered meets the mammography accreditation standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a Physician's interpretation of the results of the procedure.

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 following a Mastectomy. Benefits will be paid for all stages and revisions of Reconstructive Breast Surgery performed on a diseased breast, as well as for prostheses and physical complications in all stages of Mastectomy, including lymphedemas. Reconstruction of the nipple/areolar complex following a Mastectomy is covered without regard to the lapse of time between the Mastectomy and the reconstruction upon approval by the treating Physician.

“Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

“Reconstructive breast surgery” means surgery performed as a result of a Mastectomy to re-establish symmetry between the two breasts, and includes reconstruction of the Mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. “Reconstructive breast surgery” also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

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. Beginning at age 50, benefits will be provided for non-symptomatic Insured Persons for one of the five screening options below:

1. Yearly fecal occult blood test (FOBT); or
2. Flexible sigmoidoscopy every five (5) years; or
3. Yearly fecal occult blood test plus flexible sigmoidoscopy every five (5) years; or
4. Double contract barium enema every five (5) years; or
5. Colonoscopy every ten (10) years.

In addition, upon recommendation of the Physician, medically necessary benefits will be provided for one or more of the screening options, based on American Cancer Society guidelines regarding family history or other factors, regardless of the age of the Insured.

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

Benefits for Anesthesia and Hospitalization for Dental Procedures

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the Physician treating the Insured involved certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

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

Benefits for Newborn Hearing Screening

Benefits will be paid the same as any other Sickness for Physician ordered newborn hearing screening.

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

Benefits for Diabetes

Benefits will be paid the same as any other Sickness for medically necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures, used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician.

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

Benefits for Prescription Contraceptives

Benefits will be paid the same as any other Sickness for any contraceptive drug or device including the insertion or removal and any medical examination associated with the use of such contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid for outpatient contraceptive services provided by a Physician.

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

Benefits for Bone Mass Measurement

Benefits will be paid the same as any other Sickness for a Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass for Qualified Individuals.

Benefits will be paid for one Bone Mass Measurement every 23 months. Benefits will be paid more frequently when medically necessary. Conditions that may be considered medically necessary include, but are not limited to: 1) monitoring beneficiaries on long-term glucocorticoid therapy of more than three months and 2) to determine the effectiveness of adding an additional treatment regimen for a Qualified Individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

"Bone mass measurement" means a scientifically proven radiologic, radioisotopic, or other procedure performed on a Qualified Individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

"Qualified individual" means any one or more of the following:

- a. an individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
- b. an individual with radiographic osteopenia anywhere in the skeleton;
- c. an individual who is receiving long-term glucocorticoid (steroid) therapy;
- d. an individual who primary hyperparathyroidism;
- e. an individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
- f. an individual who has a history of low-trauma fractures; or
- g. an individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

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

Definitions

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COPAYMENT means a fixed dollar amount that an Insured must pay each time Covered Medical Expenses are provided.

CREDITABLE COVERAGE means benefits or coverage provided under:

- a. A group health plan as defined in G.S. 58-68-25(a)(4b).
- b. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.
- c. Part A or part B of title XVIII of the Social Security Act.
- d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
- e. Chapter 55 of title 10, United States Code.
- f. A medical care program of the Indian Health Service or of a tribal organization.
- g. A State health benefits risk pool.
- h. A health plan offered under chapter 89 of title 5, United States Code.
- i. A public health plan (as defined in federal regulations).
- j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)).
- k. Title XXI of the Social Security Act (State Children's Health Insurance Program).

DEPENDENT means the spouse (husband or wife) of the Named Insured and their dependent, unmarried children. 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;

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).

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.

IN-NETWORK COVERED MEDICAL EXPENSES means Covered Medical Expenses that are received under the terms of the policy from providers under contract with or approved in advance by the Company and means Medical Emergency services regardless of the status or affiliation of the provider of such services.

NEWBORN INFANT, ADOPTED OR FOSTER CHILD means any child born of an Insured or placed with an Insured while that person is insured under this policy. Such child will be covered under the policy from the moment of birth or placement for the first 31 days after birth or placement. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects or birth abnormalities including treatment of cleft lip and cleft palate, prematurity and nursery care. The Pre-existing Conditions limitation will not apply to a Newborn Infant, Adopted or Foster Child. The Insured will have the right to continue such coverage for the child beyond the first 31 days. If additional premium is required to continue the coverage, the Insured must, within the 31 days after the child's birth or placement: 1) apply to us; and 2) pay the required additional premium 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 child's birth or placement.

If family coverage is in force and no additional premium is required, enrollment/notification of the new Dependent within the specified period of time will not be required nor penalties applied for failure to do so.

OUT-OF-NETWORK COVERED MEDICAL EXPENSES means non-emergency Covered Medical Expenses that are not received according to the terms of the policy including services from affiliated providers that are received without the approval of the Company

PRE-EXISTING CONDITION means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within a twelve-month period immediately preceding the Insured's Effective Date under the policy.

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.

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. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for a Newborn Infant or Adopted or Foster Child; removal of warts, non-malignant moles and lesions;
2. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
3. Elective Surgery or Elective Treatment;
4. Elective abortion;
5. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses; except when due to a disease process;
6. 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;
7. Hearing examinations; except as specifically provided in the Benefits for Newborn Hearing Screening 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, apart from the disease process;
8. Hirsutism; alopecia;
9. Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenics, 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;
10. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act;
11. Injury sustained while (a) participating in any interscholastic, club, 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;
12. Organ transplants, including organ donation;
13. Voluntary participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
14. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months; The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy;
15. 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;

- c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI);
 - 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 or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
 - h. Growth hormones; or
 - i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
16. 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;
 17. 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;
 18. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness;
 19. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
 20. 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;
 21. Suicide or attempted suicide while sane or insane (including drug overdose); or intentional self-inflicted Injury;
 22. Supplies, except as specifically provided in the policy;
 23. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
 24. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and
 25. 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).

Collegiate Assistance Program

Insured Students have access to nurse advice and health information 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID Card. The Collegiate Assistance Program is staffed by Registered Nurses who can help students determine if they need to seek medical care, understand their medications or medical procedures, or learn ways to stay healthy.

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.

External Review Notice

North Carolina law provides for review of noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. The Company will notify you in writing of your right to request an external review each time you: receive a noncertification decision, or receive an appeal decision upholding a noncertification decision, or receive a second-level grievance review decision upholding the original noncertification.

In order for your request to be eligible for external review, the NCDOI must determine the following:

that your request is about a medical necessity determination that resulted in a noncertification decision; that you had coverage with the company in effect when the noncertification decision was issued; that the service for which the noncertification was issued appears to be a covered service under your policy; and that you have exhausted the company's internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a **standard** external review, you will be considered to have exhausted the internal review process if you have: completed the company's appeal and second level grievance review and received a written second level determination from the company, or filed a second level grievance and except to the extent that you have requested or agreed to a delay, have not received the company's written decision within 60 days of the date you submitted the request, or received notification that the company has agreed to waive the requirement to exhaust the internal appeal and second level grievance process.

If your request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed the company's internal review process and received a written final determination from the company.

If you wish to request a standard external review, you (or your representative) must make this request to NCDOI within 120 days of receiving the company's written notice of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of your request for a standard external review, the NCDOI will notify you and your provider of whether your request is complete and whether it is accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 days of the date of Healthplan's written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include: the name and contact information for the Independent Review Organization (IRO) assigned to your case; a copy of the information about your case that the company has provided to the NCDOI; notice that the company will provide you with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and notification that you may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within 7 days of the date of the acceptance notice.

If you choose to provide any additional information to the IRO, you must also provide that same information to the company at the same time using the same means of communication (e.g., you must fax the information to the company if you faxed it to the IRO).

When faxing information to the company send it to 1-800-767-0700. If you choose to mail your information, send it to:

The Company

P.O. Box 809025

Dallas, TX 75380-9025

Please note that you may also provide this additional information to the NCDOL within the 7-day deadline rather than sending it directly to the IRO and the company. The NCDOL will forward this information to the IRO and the company within two business days of receiving your additional information.

The IRO will send you written notice of its determination within 45 days of the date the NCDOL received your standard external review request. If the IRO's decision is to reverse the noncertification, the Company will, reverse the noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If you are no longer covered by the Company at the time the Company receives notice of the IRO's decision to reverse the noncertification, the Company will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An **expedited** external review of a noncertification decision may be available if you have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written request to the NCDOL for an expedited review after you: receive a noncertification decision from the Company AND file a request with the Company for an expedited appeal, or receive an appeal decision upholding a noncertification decision AND file a request with the Company for an expedited second level grievance review, or receive a second-level grievance review decision upholding the original noncertification.

You may also make a request for an expedited external review if you receive an adverse second-level grievance review decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOL will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within 3 business days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOL may: (1) accept the case for standard external review if the Company's internal review process was already completed, or (2) require the completion of the Company's internal review process before you may make another request for an external review with the NCDOL. An expedited external review is not available for retrospective noncertifications.

The IRO will communicate its decision to you within 4 business days of the date the NCDOL received your request for an expedited external review. If the IRO's decision is to reverse the noncertification, the Company will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If you are no longer covered by the Company at the time the Company receives notice of the IRO's decision to reverse the noncertification, the Company will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on the Company and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification decision for which you have already received an external review decision.

For further information about External Review or to request an external review, contact the NCDOL at:

By Mail:

NC Department of Insurance
Healthcare External Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax)919-807-6865

In Person:

Dobbs Building
430 N. Salisbury St.
4th Floor, Suite 4105
Raleigh, NC
(Toll-free in NC) 1-877-885-0231
(Out of NC) 1-919-807-6860

www.ncdoi.com for External Review information and Request Form

Managed Care Patient Assistance Program

The Managed Care Patient Assistance Program (MCPAP) is available to assist you with insurance related problems and questions. You may contact the Managed Care Patient Assistance Program at:

Telephone: (919) 733-6272 or toll free (866) 867-6272

In writing: FAX (919) 733-6276 or
Managed Care Patient Assistance Program
Consumer Protection Division
Office of Attorney General
9001 Mail Service Center
Raleigh, NC 27699-9001

General Provisions

ENTIRE CONTRACT CHANGES: This 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 this 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.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces. [[Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment.] [The Named Insured may purchase optional coverages for himself or for himself and all Dependent family members.]]

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, [P.O. Box 809026, Dallas, Texas 75380-9026].

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Insured has given the Company written notice of discontinuance.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025, or to any authorized agent of the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 180 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: 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.

LEGAL ACTIONS: 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.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

CERTIFICATE OF CREDITABLE COVERAGE: A certificate of creditable coverage will be provided to the Insured at the time coverage ceases under the plan, and upon request of behalf of the insured made no later than 24 months after the date coverage ended. The certification will be a written certification of the period of creditable coverage of the insured under the plan and any waiting period and affiliation period, if applicable, imposed with respect to the Insured for any coverage under the policy.

Claim Procedure

In the event of Injury or Sickness, Students should:

- 1) Report to their Physician or Hospital.
- 2) 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. A Company claim form is not required for filing a claim.
- 3) Bills must be received by the Company within 180 days of service or as soon as resonantly possible to be considered for payment. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Direct all CUSTOMER SERVICE OR claims inquiries to:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas Texas 75380-9025
1-800-767-0700
Customerservice@uhcsr.com
Claims@uhcsr.com

The Plan is underwritten by:

UnitedHealthcare Insurance Company

For General Information Regarding Plan Administration:

Ken Costley
College Health Concepts, Inc.
521 Atlanta Country Club Drive
Marietta GA 30067
(770) 392-4221
1-800 284-4221

Online Access to Account Information

UnitedHealthcare **Student**Resources insureds have online access to claims status, Explanation of Benefits, correspondence and coverage information via My Account at www.uhcsr.com. Insureds can also print a temporary ID card, request a replacement ID card and locate network providers from My Account.

If you don't already have an online account, simply select the "Create an Account" link from the home page at www.uhcsr.com. Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from www.uhcsr.com to access your account information.

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the Seminary 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 payment of benefits.**

Policy Number: 2011-2248-2

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