



2009-2010

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Specifically for Students of Colleges and
Universities in the Wisconsin Association of Independent
Colleges and Universities



Study Abroad Program



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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 888-302-6182 or by visiting us at www.uhcsr.com.

Eligibility

All students affiliated with the Wisconsin Association of Independent Colleges and Universities (at a participating institution) while actively engaged in a Wisconsin Association of Independent Colleges and Universities Study Abroad program are required to purchase 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 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 and grandchildren under 19 years of age who are not self-supporting.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy becomes effective August 1, 2009. 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 July 31, 2010. 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. No more than 12 months coverage may be purchased per policy year.

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 Totally Disabled 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

Avidyn 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 notification of any admission due to Medical Emergency.

Avidyn 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 Medical Expense Benefits - Injury & Sickness

Up To \$100,000 Maximum Benefit Paid as Specified Below

(For Each Injury or Sickness)

Deductible \$100 (For Each Injury or Sickness)

The Policy provides benefits for 100% of the Usual & Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of \$100,000.

Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:

Max = Maximum PA = Preferred Allowance U&C = Usual & Customary Charges

INPATIENT

<p>Hospital Expense, daily semi-private room rate; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests and 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.</p>	<p>100% of U&C</p>
<p>Intensive Care</p>	<p>100% of U&C</p>
<p>Routine Newborn Care, 4 days Hospital Confinement expense maximum, while Hospital Confined; and routine nursery care provided immediately after birth.</p>	<p>Paid as any other Sickness</p>
<p>Physiotherapy</p>	<p>Paid under Hospital Expense</p>

INPATIENT	
Surgeon's Fees , in accordance with data provided by Ingenix. 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.	100% of U&C
Anesthetist , professional services in connection with Inpatient surgery.	100% of U&C
Assistant Surgeon	No Benefits
Registered Nurse's Services , private duty nursing care.	100% of U&C
Physician's Visits , benefits are limited to one visit per day and do not apply when related to surgery.	100% of U&C
Pre-Admission Testing , payable within 3 working days prior to admission.	100% of U&C
Psychotherapy/Alcohol & Drug Abuse , benefits are limited to one visit per day.	See Benefits for Psychotherapy , page 11
OUTPATIENT	
Surgeon's Fees , in accordance with data provided by Ingenix. 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.	100% of U&C
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.	100% of U&C
Anesthetist , professional services administered in connection with outpatient surgery.	100% of U&C
Assistant Surgeon	No Benefits

OUTPATIENT	
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.	100% of U&C
Physiotherapy , benefits are limited to one visit per day.	100% of U&C
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.	100% of U&C
X-rays & Laboratory	100% of U&C
Injections , when administered in the Physician's office and charged on the Physician's statement.	100% of U&C
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	100% of U&C
Chemotherapy & Radiation Therapy	100% of U&C
Prescription Drugs	100% of U&C / \$500 max Per Policy Year
Psychotherapy/Alcohol and Drug Abuse , including all related or ancillary charges incurred as a result of a Mental or Nervous Disorder, Alcoholism and Drug Abuse, except for Prescription Drugs and Diagnostic Testing. Benefits are limited to one visit per day.	See Benefits for Psychotherapy, page 11
OTHER	
Ambulance Services	100% of U&C / \$500 max
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	100% of U&C
Consultant Physician Fees , when requested and approved by the attending Physician.	100% of U&C
Dental Treatment , made necessary by Injury to Sound, Natural Teeth and removal of wisdom teeth.	Paid as any other Injury
Maternity & Complications of Pregnancy	Paid as any other Sickness

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. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/AFP Screening and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-888-302-6182.

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	\$ 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.

Coordination of Benefits Provision

Benefits will be coordinated with any other medical, surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

Mandated Benefits

Benefits for Diabetes Expense

Benefits will be paid the same as any other Sickness for the treatment of diabetes including diabetic self-management education programs, the installation and use of an insulin infusion pump, and all other equipment and supplies, including insulin or any other prescription medication used in the treatment of diabetes. This benefit is limited to the purchase of one insulin infusion pump per policy year. The Company may require the Insured Person to use an insulin infusion pump for 30 days prior to purchase.

This benefit is subject to all Deductible, copayments, coinsurance, limitations or any other provisions of the Policy.

Benefits for Kidney Disease

Benefits will be paid for the Usual and Customary Charges for treatment of kidney disease including kidney dialysis and/or kidney transplantation. The Company will pay to or on behalf of such Insured Person the charges incurred for the treatment of such kidney disease up to \$30,000.00 during any policy year.

If such kidney disease requires kidney transplantation, the charges incurred by both the recipient and donor of the transplanted kidney shall be considered a covered expense under this provision, subject to the maximum benefit of \$30,000.00 during any policy year. Any benefits provided by the terms of this provision shall reduce benefits payable under any other benefit provisions of this policy to the extent of benefits paid under this provision.

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

Benefits for Breast Reconstruction

Benefits will be paid the same as any other Sickness for breast reconstruction of the affected tissue resulting from a surgical procedure known as a mastectomy.

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 immunization services and supplies for Dependent children 6 years of age and under. Childhood immunizations include: Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hemophilus Influenza B, Hepatitis B. and Varicella.

These services shall be exempt from any Deductible, coinsurance or any copayment provisions of this Policy.

Benefits for Mammography

Benefits will be paid the same as any other Sickness for mammography screening according to the following guidelines:

1. For women from age 45 to 49, benefits will be provided for two examinations by low-dose mammography performed when the woman is age 45 to 49, if all of the following are satisfied.
 - a. Each examination by low-dose mammography is performed at the direction of a licensed Physician or a nurse practitioner, except as provided in paragraph 3.
 - b. The woman has not had an examination by low-dose mammography within 2 years before the examination is performed.

If the woman had obtained one or more examinations by low-dose mammography while between the ages of 45 and 49 and before obtaining coverage under this insurance policy, benefits will be reduced to the extent that no more than the two required examinations between the ages of 45 and 49 are provided including the prior examinations.

2. For women age 50 or older, benefits will be provided for an annual examination by low-dose mammography to screen for the presence of breast cancer, if the examination is performed at the direction of a licensed Physician or a nurse practitioner, except as provided in paragraph 3.
3. Benefits will be provided for an examination by low-dose mammography that is not performed at the direction of a licensed Physician or a nurse practitioner but that is otherwise required to be covered under paragraphs 1 and 2, if all of the following are satisfied.
 - a. The woman does not have an assigned or regular Physician or nurse practitioner when the examination is performed.
 - b. The woman designates a Physician to receive the results of the examination.
 - c. An examination by low-dose mammography previously obtained by the woman was at the direction of a licensed Physician or a nurse practitioner.

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

Benefits for Skilled Nursing

Benefits will be provided for 30 days of skilled nursing care to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a general Hospital. The daily rate payable shall not exceed the maximum daily rate established for licensed skilled nursing care facilities by the department of health and social services. Coverage applies only to skilled nursing care which is certified as Medically Necessary by the attending Physician and is recertified as Medically Necessary every 7 days. Skilled nursing care must be for the same medical or surgical condition for which the Insured has been treated at the Hospital prior to entry into the skilled nursing care facility. These benefits do not apply to care which is essentially domiciliary or custodial, or to care which is available to the Insured without charge or under a governmental health care program, except Medicaid.

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

Benefits for Home Care

If visits are required at the home of an Insured Person and such visits are provided or coordinated by a state-licensed or Medicare-certified home health agency or a certified rehabilitation agency, the Company will pay to or on behalf of such Insured Person the usual and customary charges incurred for such services according to the following guidelines:

Covered charges will be payable under these Home Care Benefits after receipt by the Company of the attending physician's certification that:

- A. Hospitalization or confinement in a skilled nursing facility would otherwise be required if visits to the home of the Insured Person are not provided; and
- B. Necessary care and treatment are not available from a person who ordinarily resides in the house of the Insured Person or from any family member, and
- C. Includes a copy of the attending Physician's "Plan of Care" which has been reduced to writing and signed by the Physician (such "Plan of Care" to be reviewed every 2 months unless the Physician indicates in writing that a longer review period is sufficient). If the Insured Person was confined in a Hospital immediately prior to the commencement of home care, the attending Physician's "Plan of Care" shall also be approved by the Physician who was the primary provider of services during the Hospital Confinement.

Covered charges do not include any services provided by any person residing with, or any family member of, any Insured Person and are limited to:

1. Visits for part-time or intermittent home nursing care by or under the supervision of a Registered Nurse;
2. Visits for part-time or intermittent home health services, under the supervision of a Registered Nurse or medical social worker, and such visits consist solely of caring for the Insured Person;
3. Visits for physical, respiratory, occupational or speech therapy;
4. Visits for nutrition counseling provided by or under the supervision of a registered dietician;
5. Charges for evaluation of the need for and development of a plan by a Registered Nurse, medical social worker or Physician extender, for visits to the home of the Insured Person;
6. Charges for medical supplies, drugs and medications prescribed by a Physician;
7. Charges for laboratory services provided by or on behalf of a Hospital; and which were included in the attending Physician's "Plan of Care."

Covered charges will be payable on the basis that each of the following is considered as one home care visit:

1. Each visit by a person providing the service; or
2. The evaluation of the need for the plan; or
3. The development of the plan; or
4. During any 24-hour period, visits by home health services of up to four consecutive hours will be considered to be one home care visit.

Benefits payable for covered charges Items (1) through (5) are limited to a maximum of 40 visits during any policy year for any Insured Person except that any Insured Person who also receives benefits under both Part A and Part B of Medicare (Title XVIII of the Social Security Act) shall, in the aggregate with benefits payable under both Part A and Part B of Medicare, be limited to a maximum of 365 visits during any policy year. Covered charges Items (6) and (7) are payable to the same extent as they would be payable during a Hospital Confinement. Any benefits provided by the terms of this provision shall reduce benefits payable under any other provisions of this policy to the extent of benefits paid under this provision.

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

Benefits for Drugs for Treatment of HIV Infection

Benefits will be payable for Prescription Drugs on the same basis as any other Sickness for the treatment of HIV Infection. "HIV infection" means the pathological state produced by a human body in response to the presence of HIV. Such Prescription Drugs must be: (a) prescribed by the insured's physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; (b) be approved by the federal food and drug administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 CFR 312.34 to 312.36 for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection and that is in, or has completed, a phase 3 clinical investigation performed in accordance with 21 CFR 312.20 to 312.33; and (c) if the drug is an investigational new drug described in (b), it is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 CFR 312.34 to 312.36.

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

***Benefits for Hospital and Ambulatory Surgery Center Charges
and Anesthetics for Dental Care***

Benefits under this section shall cover Hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care that is provided to an insured in a Hospital or ambulatory surgery center, if any of the following applies:

1. The Insured is a child under the age of 5.
2. The Insured has a medically established chronic disability.
3. The Insured has a medical condition that requires hospitalization or general anesthesia for dental care.

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

Benefits for Temporomandibular Disorders

Benefits will be paid the same as any other Injury or Sickness for diagnostic procedures and medically necessary surgical and nonsurgical treatment for the correction of temporomandibular disorders if all the following apply:

1. The condition is caused by congenital, developmental or acquired deformity, disease, or Injury.
2. Under the accepted standards of the profession of the health care provider rendering the service, the procedure or the device is reasonable and appropriate for the diagnosis or treatment of the condition.
3. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Benefits for nonsurgical treatment including prescribed intraoral splint therapy devices will not exceed \$1,250 annually.

Benefits will not be provided for cosmetic or elective orthodontic care, periodontic care or general dental care.

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

Benefits for Cancer Clinical Trials

Benefits will be paid the same as any other Sickness for Routine Patient Care that is administered to an Insured Person in all phases of a cancer clinical trial.

Routine Patient Care includes:

- 1) All health care services, items and drugs for the treatment of cancer.
- 2) All health services, items, and drugs that are typically provided in health care; including health care services, items, and drugs provided to a patient during the course of treatment in a cancer clinical trial for a condition or any of its complications; and that are consistent with the usual and customary standard of care, including the type and frequency of any diagnostic modality.

Routine Patient Care does not include the health care service, item, or investigational drug that is the subject of the cancer clinical trial; any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; an investigational drug or device that has not been approved for market by the federal food and drug administration; transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the cancer clinical trial; any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any patient; or any services, items, or drugs that are eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

The cancer clinical trial must meet all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
3. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
4. The trial does one of the following:
 - a. Tests how to administer a health care service, item, or drug for the treatment of cancer.
 - b. Tests responses to a health care service, item, or drug for the treatment of cancer.
 - c. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer.
 - d. Studies new uses of health care services, items, or drugs for the treatment of cancer.
5. The trial is approved by one of the following:
 - a. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services.
 - b. The federal food and drug administration.
 - c. The federal department of defense.
 - d. The federal department of veterans affairs.

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

Benefits for Psychotherapy

(The Treatment of Mental and Nervous Disorder, Alcoholism and Drug Abuse)

Benefits will be paid the same as any other Sickness for the treatment of Mental and Nervous Disorder, Alcoholism and Drug Abuse on the same basis as any other Sickness subject to the following limitations:

Benefits while Hospital Confined, will not exceed \$7,000 per policy year.

Benefits for outpatient treatment will not exceed \$2,000 per policy year.

Benefits for transitional treatment arrangements will not exceed \$3,000 per policy year.

“Transitional treatment arrangements” means services, as specified by rule by the Commissioner, for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems that are provided to an Insured in a less restrictive manner than are inpatient Hospital services, but in a more intensive manner than are outpatient services.

As specified by the Commissioner by rule, the following are considered covered services and programs for Transitional Treatment Arrangements:

- 1) Mental health services in a Day Treatment Program offered by a provider certified by the DHSS under ss. HSS 61.75 and 61.81;
- 2) Services for an Insured Person with chronic Mental and Nervous Disorder provided through a community support program certified by the DHSS under s. HSS 63.03;
- 3) Residential treatment programs for alcohol or drug dependent persons or both certified by the DHSS under s. HSS 61.60;
- 4) Services for alcoholism and other drug problems provided in a Day Treatment Program certified by the DHSS under s. HSS 61.61; and
- 5) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided by specialists in addiction medicine according to the patient placement criteria of the American Society of Addiction Medicine.

“Day treatment programs”, also known as partial hospitalization, are nonresidential programs that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week. Residential treatment programs are therapeutic programs for alcohol and drug dependent persons. They include therapeutic communities and transitional facilities.

The American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders is used to determine the Medical Necessity of transitional treatment for Alcoholism and Drug Abuse. The Medical Necessity of transitional treatment for Mental and Nervous Disorders is based on the following criteria: 1) varying or daily ambivalence to treatment; 2) Insured at risk of relapse or severe consequences of relapse; 3) existence of mild interference with daily functioning or disturbing symptoms that significantly interfere with functioning. The Insured's Mental and Nervous Disorder must meet at least one of these criteria to qualify for transitional treatment benefits.

The benefit amounts specified above shall not include costs incurred for Prescription Drugs or diagnostic testing. Benefits for Prescription Drugs and diagnostic testing will be paid the same as any other Sickness in addition to these benefit limits.

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

Benefits for Lead Poisoning Screening

Benefits will be provided for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the Department of Health and Family Services.

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

Definitions

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.

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. Acupuncture; allergy testing;
2. Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
3. Assistant Surgeon Fees;
4. Autistic disease of childhood, hyperkinetic syndromes, milieu therapy, learning disabilities, behavioral problems, parent-child problems, attention deficit disorder, conceptual handicap, developmental delay or disorder or mental retardation;
5. Biofeedback;
6. Chronic pain disorders;
7. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
8. 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;
9. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;
10. Dental treatment, except as specifically provided in the Schedule of Benefits;
11. Elective Surgery or Elective Treatment;
12. Elective Abortion;

13. 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 due to a disease process;
14. 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;
15. 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;
16. Hirsutism; alopecia;
17. Hypnosis;
18. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
19. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
20. 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;
21. Investigational services;
22. Lipectomy;
23. Organ transplants, including organ donation except as specifically provided in the Benefits for Kidney Disease;
24. Marital or family counseling;
25. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
26. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:
 - a) Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use;
 - b) Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use;
 - c) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - d) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - e) Products used for cosmetic purposes;
 - f) Drugs used to treat or cure baldness; anabolic steroids used for body building;
 - g) Anorectics - drugs used for the purpose of weight control;
 - h) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
 - i) Growth hormones; or
 - j) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

27. 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;
28. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study; except as provided in the Benefits for Cancer Clinical Trials;
29. 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;
30. 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;
31. Services provided normally without charge by the Health Service of the Policyholder;
32. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of chronic purulent sinusitis;
33. 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;
34. Sleep disorders;
35. Speech therapy; naturopathic services;
36. Supplies, except as specifically provided in the policy;
37. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
38. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
39. 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
40. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

Scholastic Emergency Services (SES) 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 services worldwide, except in your home country.

Domestic Students, insured spouse and insured minor child(ren): You are eligible for SES services 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 services include Emergency Medical Evacuation and Return of Mortal Remains that meet the U.S. 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, any services not arranged by SES will not be considered for payment.

Key Services include:

- * Medical Consultation, Evaluation and Referrals
- * Foreign Hospital Admission Guarantee
- * Emergency Medical Evacuation
- * Critical Care Monitoring
- * Medically Supervised Repatriation
- * Prescription Assistance
- * Transportation to Join Patient
- * Emergency Counseling Services
- * Lost Luggage or Document Assistance
- * 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
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. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure for Program Guidelines as well as limitations and exclusions pertaining to the SES program.

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.

Online Access to Account Information

UnitedHealthcare **StudentResources** Insureds have online access to claims status, EOBs, 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 BROCHURE AS A GENERAL SUMMARY OF THE INSURANCE. The Master Policy on file at the Association contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

Claim Procedure

In the event of Injury or Sickness, students should:

- 1) Report to the Student Health Service for treatment, or when not in school, 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 or university under which the student is insured. A Company claim form is not required for filing a claim.
- 3) File claim within 30 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 will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by
United HealthCare Insurance Company

Submit all Claims or Inquiries to:
UnitedHealthcare **StudentResources**
P.O. Box 809025
Dallas, Texas 75380-9025
1-888-302-6182

customerservice@uhcsr.com
claims@uhcsr.com

Sales/Marketing Services:
UnitedHealthcare **StudentResources**
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
727-563-3400
1-800-237-0903
E-Mail: info@uhcsr.com