

DOMESTIC STUDENT PLAN

2010-2011

STUDENT

INJURY AND SICKNESS

INSURANCE PLAN

DESIGNED ESPECIALLY FOR THE STUDENTS AT MEMBER COLLEGES OF THE

MISSOURI COMMUNITY COLLEGE ASSOCIATION



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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 detailed copy of our privacy policy by calling us toll-free at 1-800-767-0700 or by visiting us at www.uhcsr.com.

Eligibility

All domestic students enrolled for 6 or more credit hours at a community college are eligible to enroll in the insurance Plan.

All insured students may purchase Major Medical coverage on an optional basis.

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 26 years of age who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student.

Optional Coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment in the Plan. Only those students enrolled in Basic coverage may purchase Optional Major Medical coverage.

Effective and Termination Dates

The Master Policy becomes effective August 1, 2010. 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, 2011. 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.

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.

Schedule of Basic Medical Expense Benefits

Injury and Sickness

\$50,000 Basic Maximum Benefit (For each Injury or Sickness)

Paid as Specified Below

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

The Policy provides benefits for the Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of \$50,000 for each Injury or Sickness.

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

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

The Deductible will be reduced to \$100 for each Injury or Sickness when the Insured is referred by the Student Health Center not to exceed \$200 maximum Per Policy Year.

All Benefit maximums are combined Preferred Provider and Out-of-Network unless noted below. Benefits will be paid up to the Maximum Benefit for each service scheduled below.

Covered Medical Expenses include:

max = maximum U&C = Usual & Customary Charges PA=Preferred Allowance

INPATIENT	Preferred Provider	Out of Network
Hospital Expense , Miscellaneous, daily semi-private room rate; and general nursing care provided by the Hospital. Hospital Miscellaneous Expense such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services & supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of U&C / \$1,100 Aggregate maximum per day
Intensive Care	80% of PA	60% of U&C / \$1,400 Aggregate maximum per day
Routine Newborn Care , while Hospital Confined; and routine nursery care provided immediately after birth.	See Benefits for Maternity Expenses	
Physiotherapy	80% of PA	Paid under Hospital Expense

INPATIENT	Preferred Provider	Out of Network
<p>Surgery, 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 subsequent procedures.</p>	80% of PA	60% of U&C / \$3,500 maximum
<p>Assistant Surgeon</p>	No Benefits	
<p>Anesthetist, professional services in connection with inpatient surgery.</p>	25% of Surgery Allowance	
<p>Registered Nurse's Services, private duty nursing care.</p>	80% of PA	60% of U&C
<p>Physician's Visits, benefits are limited to one visit per day and do not apply when related to surgery.</p>	80% of PA	60% of U&C
<p>Pre-Admission Testing, payable within 3 working days prior to admission.</p>	Paid under Hospital Miscellaneous	
<p>Mental Illness</p>	See Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse	
OUTPATIENT		
<p>Surgery, 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 subsequent procedures.</p>	80% of PA	60% of U&C / \$3,500 maximum
<p>Assistant Surgeon</p>	No Benefits	
<p>Day Surgery Miscellaneous, related to surgery performed in a Hospital, including the cost of the operating room; laboratory tests & x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual & Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.</p>	80% of PA / \$2,000 maximum	60% of U&C / \$1,200 maximum

OUTPATIENT	Preferred Provider	Out of Network
Outpatient Miscellaneous Benefit , includes benefits designated as Paid under Outpatient Miscellaneous Benefit (OMB).	80% of PA / \$2,000 maximum	60% of U&C / \$1,200 maximum
Anesthetist , professional services administered in connection with outpatient surgery.	25% of Surgery Allowance	
Physician's Visits , benefits are limited to one visit per day and do not apply when related to surgery or Physiotherapy. <i>(The \$15 copay/Deductible per visit is in addition to the Policy Deductible.)</i>	Paid under OMB / \$15 copay per visit	Paid under OMB / \$15 Deductible per visit
Physiotherapy , benefits are limited to one visit per day.	Paid under Outpatient Miscellaneous Benefit	
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.	Paid under Outpatient Miscellaneous Benefit	
Diagnostic X-Ray Services	Paid under Outpatient Miscellaneous Benefit	
Injections , when administered in the Physician's office and charged on the Physician's statement.	Paid under Outpatient Miscellaneous Benefit	
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays & Lab Procedures.	Paid under Outpatient Miscellaneous Benefit	
Radiation Therapy / Chemotherapy	Paid under Outpatient Miscellaneous Benefit	
Laboratory Services <i>(The \$15 copay / Deductible per visit is in addition to the Policy Deductible.)</i>	Paid under OMB / \$15 copay per visit	Paid under OMB / \$15 Deductible per visit
Prescription Drugs <i>(\$500 maximum)</i>	50% of U&C	
Mental Illness	See Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse	

OTHER	Preferred Provider	Out of Network
Ambulance Services <i>(\$500 maximum)</i>	80% of PA	80% of U&C
Consultant Physician Fees , when requested and approved by the attending Physician. <i>(\$100 maximum)</i>	80% of PA	60% of U&C
Durable Medical Equipment	No Benefits	
Dental Treatment , made necessary by Injury to Sound, Natural Teeth. <i>(\$250 per tooth maximum)</i>	80% of U&C	
Alcoholism/Chemical Dependency	See Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse	
Maternity	See Benefits for Maternity Expenses	
Elective Abortion	No Benefits	
Complications of Pregnancy	Paid as any other Sickness	
CAT Scan/MRI <i>(\$750 maximum)</i>	80% of PA	60% of U&C
Well-Child Care , benefits shall include coverage for Child Health Supervision Services from the moment of birth to 16 years of age. "Child Health Supervision Services shall include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Minimum Benefits are limited to one visit payable to one provider for all services provided at each visit. Benefits are subject to all copayment, coinsurance, limitations, or any other provisions of the policy.) <i>(\$750 maximum)</i>	80% of PA	60% of U&C

Preferred Provider Information

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

UnitedHealthcare Options PPO

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

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

“Network Area” means the 50 mile radius around the local school campus the Named Insured is attending.

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

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

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at 80%, up to any limits specified in the Schedule of Benefits. Call (800) 767-0700 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided UnitedHealthcare Options PPO will be paid at 80% of Preferred Allowance or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Optional Major Medical Benefit

\$50,000 Maximum Benefit (For Each Injury or Sickness)

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

The Major Medical Benefit begins payment after the Basic Maximum Benefit of \$50,000 has been paid by the Company.

The Company will pay 100% for additional Covered Medical Expenses incurred up to the Major Medical Maximum of \$50,000. The total benefit payable under Major Medical is \$100,000 minus the Basic Benefits already paid.

No benefits will be paid under Major Medical for:

1. Room & Board Expenses / Hospital Miscellaneous Expenses which exceed \$1,100 per day;
2. Intercollegiate Sports;
3. Dental;
4. Outpatient Physiotherapy;
5. Pre-existing Conditions; Any condition which is diagnosed; treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under Optional Major Medical coverage; except for individuals who have been continuously insured under Optional Major Medical coverage 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 coverage.

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 1-800-767-0700.

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

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

For Loss of:

	<u>Student</u>	<u>Dependent</u>
Life	\$10,000	\$5,000
Two or More Members	\$10,000	\$5,000
One Member	\$ 5,000	\$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 Mammography

Benefits will be paid the same as any other Sickness for Low-dose Mammography for the presence of occult breast cancer. Benefits will be provided according to the following guidelines:

1. A single baseline mammogram for women thirty-five to thirty-nine years of age.
2. A mammogram not less than once every two years for women forty to forty-nine years of age or more often for women with risk factors to breast cancer if recommended by her Physician.
3. A mammogram every year for women fifty and over.
4. A mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer.

"Low-dose mammography" means the x-ray examination of the breast, using equipment dedicated specifically for mammography including but not limited to the x-ray tub, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

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

Benefits for Prosthetic Device and Reconstructive Surgery

Benefits will be paid the same as any other Sickness for a Mastectomy and the initial prosthetic device or reconstructive surgery necessary to restore symmetry incident to the Mastectomy when recommended by a Physician.

No time limit shall be imposed on an Insured Person for the receipt of prosthetic devices or reconstructive surgery while covered under the policy.

"Mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a Physician.

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

Benefits for Cytologic Screening

Benefits will be paid the same as any other Sickness for a pelvic examination and cytologic screening (pap smear) for an Insured in accordance with the current American Cancer Society guidelines.

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 a colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic Insured Person in accordance with the current American Cancer Society guidelines.

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

Benefits for Prostate Screening

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer for an Insured in accordance with the current American Cancer Society guidelines.

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

Benefits for Second Opinion for Newly Diagnosed Cancer

Benefits will be paid the same as any other Sickness for a second opinion rendered by a Physician specializing in that specific cancer diagnosis area when an Insured with a newly diagnosed cancer is referred to such Physician specialist by his or her attending Physician.

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

Benefits for Clinical Trial for Cancer Treatment

Benefits will be paid the same as any other Sickness for the medically necessary treatment for Routine Patient Care Costs associated with Cancer Clinical Trials.

The provisions of this section shall not be construed to affect compliance or coverage for off-label use of drugs not directly affected by this section.

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

A detailed description of the benefits and restrictions for Cancer Clinical Trials is available in the Master Policy on file at the school or by calling the Company at 1-800-767-0700.

Benefits for Osteoporosis

Benefits will be paid the same as any other Sickness for services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a Physician for Insureds with a condition or medical history for which bone mass measurement is medically indicated. In determining whether testing or treatment is medically appropriate, due consideration will be given to peer reviewed medical literature.

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

Benefits for Immunizations

Benefits will be paid the same as any other Sickness for immunizations of a child from birth to five years of age as provided by department of health regulations.

Benefits shall not be subject to any Deductible or copayment limits.

Human Leukocyte Antigen Testing Benefit

Benefits will be paid the same as any other Sickness for Human Leukocyte Antigen Testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Benefits will be limited to one such testing per lifetime, not to exceed \$75.00.

The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists.

At the time of testing, the Insured being tested must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

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

Benefits for Phenylketonuria

Benefits will be paid the same as any other Sickness for formula and Low Protein Modified Food Products recommended by a Physician for the treatment of phenylketonuria (PKU) or any inherited disease of amino and organic acids for an Insured less than six (6) years of age. Benefits will not exceed \$5,000 per policy year.

"Low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

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

Contraceptive Benefit

The Policyholder provides benefits for Contraceptives the same as any other Prescription Drug or device under this policy.

"Contraceptives" means all prescription drugs and devices approved by the Federal Food and Drug Administration for use as a contraceptive but shall exclude all drugs and devices that are intended to induce an abortion.

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

If, for moral, ethical or religious beliefs, you do not want benefits for contraceptive drugs or devices, contact the Company at 1-800-767-0700.

Benefits for Newborn Hearing Screening

Benefits will be paid the same as any other Sickness for Dependent Newborn Infants for hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

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

Benefits for Dental General Anesthesia

Benefits will be paid the same as any other Sickness for administration of general anesthesia and Hospital charges for dental care to a Dependent child under the age of five, an Insured who is severely disabled, or an Insured who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

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

Benefits for Maternity Expenses

Benefits will be paid the same as any other Sickness for a minimum of 48 hours for inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery. Post-discharge care will be payable for up to two visits, one of which shall be in the home. A Physician shall determine the location and schedule of the post-discharge visits. Services shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization.

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

Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse

Benefits will be paid the same as any other Sickness for medically necessary recognized Mental Illness treatment by a Physician.

"Mental Illness" as used in this benefit provision means the following disorders contained in the International Classification of Diseases (ICD-9-CM): (a) Schizophrenic disorders and paranoid states (295 and 297, except 297.3); (b) Major depression, bipolar disorder, and other affective psychoses (296); (c) Obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81); (d) Early childhood psychoses, and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314); (e) Alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); (f) Anorexia nervosa, bulimia and other severe eating disorders (307.1, 307.51, 307.52 and 307.53); and (g) Senile organic psychotic conditions (290).

Additional Limitations and Exclusions:

Alcohol and Drug Abuse treatment services are limited to a minimum of thirty (30) days total inpatient treatment and a minimum of twenty (20) total visits for outpatient treatment for each Policy Year. The Lifetime Maximum is limited to four times the Policy Year maximum. The days allowed for inpatient treatment can be converted for use for outpatient treatment on a two-for-one basis.

No benefits will be paid for: (1) Marital, family, educational, or training services unless medically necessary and clinically appropriate; (2) Services rendered or billed by a school or halfway house; (3) Care that is custodial in nature; (4) Services and supplies that are not medically necessary nor clinically appropriate; or (5) Treatments that are considered experimental.

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

Definitions

INJURY means accidental bodily injury sustained, directly and independently of all other causes; treated by a Physician within 30 days after the date of accident and while the Insured Person is covered under this policy. 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.

PRE-EXISTING CONDITION means any condition which is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

SICKNESS means sickness or disease of the Insured Person which causes loss 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.

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Named Insured unable to actively attend class. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

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. Acne; acupuncture; allergy; including 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. Biofeedback;
5. Durable Medical Equipment;
6. Circumcision;
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. Dental treatment, except as specifically provided in Benefits for Dental General Anesthesia or for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery or Elective Treatment;
11. Elective abortion, unless elected by the Policyholder and an additional premium charged;
12. 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;
13. 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;
14. Unless coverage is elected by the Policyholder, hearing examinations or hearing aids; or other treatment for hearing defects and problems, except as specifically provided in Benefits for Newborn Hearing Screening. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
15. Hirsutism; alopecia;
16. Immunizations, except as specially provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
17. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
18. 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;

19. Lipectomy;
20. Organ transplants, including organ donation;
21. Marital or family counseling;
22. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
23. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 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;
24. 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;
 - 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 as specifically provided in Benefits for Clinical Trial for Cancer Treatment;
 - 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.
25. 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;
26. 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; except as specifically provided in the policy;
27. 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;

28. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
29. 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;
30. Sleep disorders;
31. Unless coverage is elected by the Policyholder, speech therapy; naturopathic services;
32. Supplies, except as specifically provided in the policy;
33. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
34. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
35. 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);
36. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

Collegiate Assistance Program

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

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:

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.

Grievance Procedure

The following levels of review are available to Insured Persons or providers who have a complaint or a Grievance.

A **Grievance** means a written complaint submitted by or on behalf of an Insured Person regarding:

- the Company's decisions, policies or actions related to availability, delivery or quality of health care services;
- claims payment, handling or reimbursement for health care services;
- the contractual relationship between an Insured Person and the Company; or
- the outcome of an Adverse Determination.

An Adverse Determination means a determination that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, and the requested service is therefore denied, reduced or terminated.

The levels of review include:

Informal Review. An Insured Person may submit an oral complaint to the Company for Informal Review after an event that causes a dispute. The Company must respond to the Insured, his/her designated representative, or the provider in writing within thirty days after receiving the complaint and any additional information requested for the Informal Review. At any time during the Informal Review, the Insured Person may submit a written request for the complaint to be reviewed through the Formal Review Process.

Formal Review. The Formal Review process includes a First Level, Second Level and Expedited Review Process.

First Level Review. An Insured Person or his or her provider, in the event of an Adverse Determination, may submit a written Grievance to the Company for review. The Insured Person will not be allowed to attend, nor have a representative attend, a First Level Review. However, the Insured Person may submit written material for the review.

Upon receipt of a request for First Level Grievance Review, the Company will:

- (1) Acknowledge receipt of the Grievance in writing within ten working days;
- (2) Conduct a complete investigation of the Grievance within twenty working days after receipt of a Grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty working days after receipt of a Grievance, the Insured shall be notified in writing on or before the twentieth working day and the investigation shall be completed within thirty working days thereafter. The notice shall set forth the reasons for the additional time needed for the investigation;
- (3) Within five working days after the investigation is completed, the Company will have someone not involved in the circumstances giving rise to the Grievance or its investigation decide upon the appropriate resolution of the Grievance and notify the Insured in writing of the Company's decision regarding the Grievance and of the right to file an appeal for a Second Level Review. The notice shall explain the resolution of the Grievance and the right to appeal in terms which are clear and specific;
- (4) Within fifteen working days after the investigation is completed, notify the person who submitted the Grievance of the Company's resolution of said Grievance.

Second Level Review. The Second Level Review process is available to Insured Persons who are not satisfied with the outcome of the First Level Review. The Insured Person, his/her designated representative, or provider may attend the Second Level Review. Persons reviewing a Second Level Grievance that involves an appeal or a clinical issue will include a provider who has appropriate expertise, other enrollees, representatives of the health carrier that were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance, and where the Grievance involves an Adverse Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance. Review by the grievance advisory panel shall follow the same time frames as a First Level Review, except as provided for in an Expedited Review, if applicable. Any decision of the grievance advisory panel shall include notice of the Insured's, the Company's or the Master Policyholder's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office.

Expedited Review. The Insured Person or his or her representative may request an Expedited Review of a Grievance orally or in writing. This level of review is available only in situations where the time frames for the Informal Review, First Level Review or Second Level Review would seriously jeopardize the life or health of an Insured Person or would jeopardize the Insured Person's ability to regain maximum function. The Company will orally notify the Insured within seventy-two hours after receiving a request for an Expedited Review of the Company's decision. Written confirmation of its decision will be sent within three working days from the date of such notification.

Insured Persons, his/her designated representative, or a provider may contact the Director of the Missouri Department of Insurance for assistance at any time at 1-800-726-7390 or write to Missouri Department of Insurance, P.O. Box 690, 301 West High Street, Truman Building, Room 630, Jefferson City, Missouri 65102-0690.

Claim Procedure

In the event of Injury or Sickness, students should:

- 1) Report to the nearest Physician or Hospital.
- 2) Mail all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the university under which the student is insured. A Company claim form is not required for filing a claim. A written notice of claim must be submitted to the address below within 90 days after expense is incurred, or as soon thereafter as reasonably possible. Upon receipt of a notice of claim, the Company will furnish the Insured the necessary forms for filing proof of loss. If the person making claim does not receive the necessary claim forms before the expiration of 15 days after first requesting such forms, the Insured shall be deemed to have complied with the requirements as to the proof of loss upon submitting to the Company within 90 days written proof covering the occurrence, character and extent of the loss for which claim is made.
- 3) File claim within 90 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service.
- 4) The Insured's failure to give notice within such time will not invalidate nor reduce any claim if it is shown that notice was given as soon as was reasonably possible. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by:
UnitedHealthCare Insurance Company

Submit all Claims or Inquiries to:
UnitedHealthcare **Student**Resources

P. O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700
claims@uhcsr.com
customerservice@uhcsr.com

Sales/Marketing Service:
UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
1-800-237-0903
[e-mail: info@uhcsr.com](mailto:info@uhcsr.com)

ONLINE SERVICES: Please visit our Website at www.uhcsr.com for Online Enrollment, Certificates, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services.

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the Missouri Community College Association contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

This Certificate is based on Policy# 2010-202001-1

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