2009-2010

STUDENT INJURY ONLY(PLAN A)
OR
INJURY AND SICKNESS(PLAN B)
INSURANCE PLAN

Designed Especially for the Students of

Connecticut Community-Technical Colleges

This Certificate does not provide Coverage for:

Skydiving, parachuting, hang gliding, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

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.

PLAN A IS AN INJURY ONLY POLICY AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS.
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 enrolled students are automatically enrolled in the School Time Injury Only Plan (Plan A 2009-201337-1) insurance plan. All enrolled students are eligible to enroll in the Optional 24 hour Injury and Sickness insurance Plan (Plan B 2009-201337-2).

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 in Plan B-2009-201337-2 may also insure their Dependents. Eligible Dependents are the spouse and unmarried children under 19 years of age or 26 as long as the child: A) is a resident of the state; or B) is in full-time attendance at an out of state accredited institution of higher education; or C) resides out of state with a custodial parent pursuant to a child custody determination. Dependent Eligibility expires concurrently with that of the Insured student.

Effective And Termination Dates

The Master Policy on file at the school becomes effective August 25, 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 August 24, 2010. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Refunds of premiums are allowed only upon entry into the armed forces. For Plan B 2009-201337-2, Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

The Policy is a Non-Renewable One Year Term Policy.

Premium Rates (Plan B 2009-201337-2)

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<tbody>
<tr>
<td>Student</td>
<td>$468.00</td>
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<tr>
<td>Spouse</td>
<td>$711.00</td>
</tr>
<tr>
<td>All Children</td>
<td>$586.00</td>
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</tbody>
</table>
Extension of Benefits After Termination
(Plan A 2009-201337-1)

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury 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 the “Extension of Benefits” provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Extension of Benefits After Termination
(Plan B 2009-201337-2)

The coverage provided under this 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 the “Extension of Benefits” provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.
The Policy provides benefits for 100% the Usual and Customary Charges (U&C) incurred, by an Insured Person, for loss due to a covered Injury up to the Maximum Benefit of $20,000 for each Injury. The Company will pay Covered Medical Expenses caused by an injury sustained by the Covered Person: a) while attending classes of the Connecticut Community Technical Colleges; or b) while participating in and while traveling directly to or from an activity sponsored by the Connecticut Community Technical Colleges (including work study programs). Intercollegiate athletics are not covered. Fluid exposures (needlesticks, face splashes, etc.) experienced by Clinical Students while engaging in school related activities in a clinic setting shall be covered (including any medically required prescriptions) at 100% up to $500 maximum per incident.

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

<table>
<thead>
<tr>
<th>U&amp;C= USUAL AND CUSTOMARY CHARGES</th>
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<tbody>
<tr>
<td><strong>INPATIENT</strong></td>
</tr>
<tr>
<td><strong>Room &amp; Board Expense</strong>, daily semi-private room rate, and general nursing care provided by the Hospital.</td>
</tr>
<tr>
<td><strong>Intensive Care</strong></td>
</tr>
<tr>
<td><strong>Hospital Miscellaneous Expense</strong>, 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.</td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
</tr>
<tr>
<td><strong>Surgeon’s Fees</strong>, 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.</td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
</tr>
<tr>
<td><strong>Anesthetist</strong>, professional services in connection with inpatient surgery.</td>
</tr>
<tr>
<td><strong>Registered Nurse’s Services</strong>, private duty nursing care.</td>
</tr>
<tr>
<td><strong>INPATIENT</strong></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Physician’s Visits</strong>, benefits are limited to one per day and do not apply when related to surgery.</td>
</tr>
<tr>
<td><strong>Pre-Admission Testing</strong>, payable within 3 working days prior to admission.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>OUTPATIENT</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgeon’s Fees</strong>, 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.</td>
<td>100% of U&amp;C</td>
</tr>
<tr>
<td><strong>Day Surgery Miscellaneous</strong>, 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.</td>
<td>100% of U&amp;C</td>
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<td><strong>Assistant Surgeon</strong></td>
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<tr>
<td><strong>Anesthetist</strong>, professional services administered in connection with outpatient surgery.</td>
<td>100% of U&amp;C</td>
</tr>
<tr>
<td><strong>Physician’s Visits</strong>, benefits are limited to one visit per day and do not apply when related to surgery or Physiotherapy.</td>
<td>100% of U&amp;C</td>
</tr>
<tr>
<td><strong>Physiotherapy / Occupational Therapy</strong>, benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy / Occupational Therapy; or 2) within the 30 days immediately following the attending Physician’s release for rehabilitation. Benefits are limited to one visit per day.</td>
<td>Paid under Physician’s Visits</td>
</tr>
<tr>
<td><strong>Medical Emergency Expenses</strong>, use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury.</td>
<td>100% of U&amp;C</td>
</tr>
<tr>
<td><strong>Diagnostic X-Rays &amp; Laboratory Services</strong></td>
<td>100% of U&amp;C</td>
</tr>
<tr>
<td><strong>Tests and Procedures</strong>, diagnostic services and medical procedures performed by a Physician, other than Physician’s Visits, Physiotherapy, x-rays and lab procedures.</td>
<td>Paid under X-rays and Laboratory Services</td>
</tr>
<tr>
<td><strong>Injections</strong>, when administered in the Physician’s office and charged on the Physician’s statement.</td>
<td>100% of U&amp;C</td>
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<tr>
<td><strong>Prescription Drugs</strong></td>
<td>No Benefits</td>
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<tr>
<td>OTHER</td>
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</tr>
<tr>
<td><strong>Ambulance</strong>, when medically necessary transport to a Hospital.</td>
<td>Maximum allowable rate established by the Department of Public Health</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong>, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.</td>
<td>100% of U&amp;C</td>
</tr>
<tr>
<td><strong>Consultant</strong></td>
<td>No Benefits</td>
</tr>
<tr>
<td><strong>Dental Treatment</strong>, made necessary by Injury to Sound, Natural Teeth.</td>
<td>100% of U&amp;C / $750 maximum</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>See Benefits for Home Health Care</td>
</tr>
</tbody>
</table>
Schedule of Medical Expense Benefits
Injury and Sickness Plan B
Up To $20,000 Maximum Benefit Paid as Specified Below
(For Each Injury or Sickness)

The Policy provides benefits for 100% the Usual and Customary Charges (U&C) incurred, by an Insured Person, for loss due to a covered Injury or Sickness up to the Maximum Benefit of $20,000 for each Injury or Sickness.

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

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<tr>
<td><strong>Hospital Miscellaneous Expense</strong>, 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.</td>
</tr>
<tr>
<td><strong>Routine Newborn Care</strong>, 4 days Hospital Confinement expense maximum</td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
</tr>
<tr>
<td><strong>Surgeon’s Fees</strong>, 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.</td>
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<td><strong>Registered Nurse’s Services</strong>, private duty nursing care.</td>
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### INPATIENT

**Physician’s Visits**, benefits are limited to one per day and do not apply when related to surgery.  
100% of U&C / $25 per day / $3,000 maximum

**Pre-Admission Testing**, payable within 3 working days prior to admission.  
Paid under Hospital Misc.

**Mental or Nervous Condition**  
Paid as any other Sickness

### 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 for the first $400 / then 80% of U&C / $2,500 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.  
100% of U&C

**Assistant Surgeon**  
No Benefits

**Anesthetist**, professional services administered in connection with outpatient surgery.  
15% of Surgery Allowance

**Physician’s Visits**, benefits are limited to one visit per day and do not apply when related to surgery or Physiotherapy.  
100% of U&C / $75 maximum

**Physiotherapy / Occupational Therapy**, benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy / Occupational Therapy; or 2) within the 30 days immediately following the attending Physician’s release for rehabilitation. Benefits are limited to one visit per day.  
Paid under Physician’s Visits

**Outpatient Miscellaneous Benefit**, includes benefits designated as paid under Outpatient Miscellaneous Benefit.  
100% of U&C / $100 maximum

**Medical Emergency Expenses**, use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or Sickness.  
100% of U&C

**Diagnostic X-Rays & Laboratory Services**  
100% of U&C / $100 maximum

**Tests and Procedures**, diagnostic services and medical procedures performed by a Physician, other than Physician’s Visits, Physiotherapy, x-rays and lab procedures.  
Paid under Outpatient Misc. Benefit
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<td><strong>Injections</strong></td>
<td>No Benefits</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>Paid under Outpatient Misc. Benefit</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>No Benefits</td>
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<td><strong>Durable Medical Equipment</strong></td>
<td>No Benefits</td>
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<td><strong>Consultant</strong>, when requested and approved by the attending Physician.</td>
<td>100% of U&amp;C $25 maximum</td>
</tr>
<tr>
<td><strong>Dental Treatment</strong>, made necessary by Injury to Sound, Natural Teeth. Exception: Benefits for In-Patient Dental Services.</td>
<td>100% of U&amp;C / $750 maximum</td>
</tr>
<tr>
<td><strong>Alcoholism / Drug Abuse</strong></td>
<td>See Benefits for Treatment of Mental or Nervous Disorder</td>
</tr>
<tr>
<td><strong>Maternity &amp; Complications of Pregnancy</strong></td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>See Benefits for Home Health Care</td>
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</table>
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.

Excess Provision (Plan A 2009-201337-1)

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

Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

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

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

Premium for each Insured Person will be paid by the Policyholder.

This Excess Provision shall not apply to the Connecticut Comprehensive Health Care Plan.

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

Benefits for Preventive Pediatric Care (Plan B 2009-201337-2)

Benefits will be paid for “Preventive Pediatric Care” for covered Dependent Children at approximately the following age intervals: Every two months from birth to six months of age, every three months from nine to eighteen months of age and annually from two through six years of age.

Benefits are limited to the services provided by or under the supervision of a single Physician during the course of one visit.

“Preventive Pediatric Care” means the periodic review of a child’s physical and emotional health from birth through six years of age by or under the supervision of a Physician. Such review shall include a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory testing keeping with prevailing medical standards.

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

Benefits for Accidental Ingestion of a Controlled Drug (Plan A & B)

Benefits will be paid for accidental ingestion or consumption of a controlled drug as required by Connecticut statute. When inpatient treatment in a Hospital, whether or not operated by the State, is required as a result of accidental ingestion or consumption of a controlled drug, benefits will be paid for the Usual and Customary Charges incurred up to a maximum of 30 days Hospital Confinement. Benefits will be paid for outpatient treatment resulting from accidental ingestion or consumption of a controlled drug up to a maximum of $500.00 for any one accident.

Benefits for Hypodermic Needles or Syringes (Plan A&B)

Benefits will be paid for the Usual and Customary Charges incurred for hypodermic needles or syringes prescribed by a licensed Physician for the purpose of administering medications for any Injury or Sickness, provided such medications are covered under the policy.

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

Benefits for Amino Acid Modified Preparations and Low Protein Modified Food Products (Plan A&B)

Benefits will be paid the same as any other Covered Medical Expense for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a Physician.

"Inherited metabolic disease" means a disease for which newborn screening is required under Connecticut Statute Title 38a, Chapter 700c, Section 19a-55 and cystic fibrosis.

"Low protein modified food product: means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

"Amino acid modified preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

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

Benefits for Diabetic Outpatient Self Management Training (Plan B Only)

Benefits will be paid the same as any other Sickness for outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if the training is prescribed by a Physician.

Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a Physician, as defined in the Policy, trained in the care and management of diabetes and authorized to provide such care within the scope of the Physician’s practice.

Covered Medical Expenses shall include:

1) Initial training visits provided to an Insured after the Insured is initially diagnosed with diabetes that is Medically Necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, up to a maximum of ten hours.

2) Training and education that is Medically Necessary as a result of a subsequent diagnosis by a Physician of a significant change in the Insured’s symptoms or condition which requires modification of the Insured’s program of self-management of diabetes, up to a maximum of four hours.

3) Training and education that is Medically Necessary because of the development of new techniques and treatment for diabetes up to a maximum of four hours.

Benefits shall be subject to all Deductible, copayments, coinsurance, limitations, or any other provisions of the policy.
Benefits for Lyme Disease Treatment (Plan B Only)

Benefits will be paid the same as any other Sickness for Lyme disease treatment including not less than thirty days of intravenous antibiotic therapy, sixty days of oral antibiotic therapy, or both, and shall provide benefits for further treatment if recommended by a Physician.

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

Benefits for Inpatient Dental Services (Plan B Only)

Benefits will be paid the same as any other Sickness for general anesthesia, nursing and related Hospital services provided in conjunction with inpatient, outpatient or one day dental services if the following conditions are met:

1) The anesthesia, nursing and related Hospital services are deemed Medically Necessary by the treating Physician.
2) The Insured is either a) a person who is determined by a Physician to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a Hospital, or b) a person who has a developmental disability, as determined by a Physician, that places the person at serious risk.

The expense of anesthesia, nursing and related Hospital services shall be deemed a Covered Medical Expense and shall not be subject to any limits on dental benefits in the Policy.

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

Benefits for Treatment of Craniofacial Disorders (Plan B Only)

Benefits will be paid the same as any other Sickness for medically necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Insureds eighteen years of age or younger. The processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No benefits are provided for cosmetic surgery.

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

Benefits for Pain Management (Plan B Only)

Benefits will be paid the same as any other Sickness for Pain treatment ordered by a Pain Management Specialist, which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

"Pain" means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves, and "pain management specialist" means a Physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

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

Benefits for Neuropsychological Testing for Children with Cancer (Plan B Only)

Benefits will be paid the same as any other Sickness without prior authorization for each Dependent child diagnosed with cancer, for neuropsychological testing ordered by a licensed Physician, to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.

Benefits shall be subject to all Deductible, copayments, coinsurance, limitations, or any other provisions of the policy.
Benefits for Home Health Care (Plan A & B)

Benefits will be paid as specified below for Injury or Sickness for home health care to residents in Connecticut.

Benefits payable shall be limited to eighty visits in any calendar year or in any continuous period of twelve months for each Insured, except in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of six months or less to live, the yearly benefit for medical social services shall not exceed two hundred dollars ($200). Each visit by a representative of a home health agency shall be considered as one home health care visit; four hours of home health aide service shall be considered as one home health care visit.

Home health care benefits are subject to an annual Deductible of fifty dollars ($50.00) for each Insured and will be subject to a coinsurance provision of not less than seventy-five per cent (75%) of the Usual and Customary Charges for such services. If an Insured is eligible for home health care coverage under more than one policy, the home health care benefits shall only be provided by that Policy which would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

"Home health care" means the continued care and treatment of a covered person who is under the care of a Physician if:

1. continued hospitalization would otherwise have been required if home health care was not provided, except in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of six months or less to live, and,
2. the plan covering the home health care is established and approved in writing by such Physician within seven days following termination of a hospital confinement as a resident inpatient for the same or a related condition for which the Insured was hospitalized, except that in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such Insured was so confined or, if such Insured was so confined, irrespective of such seven-day period, and
3. such home health care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live.

Home health care shall be provided by a home health agency. "Home health agency" means an agency or organization which meets each of the following requirements:

1. It is primarily engaged in and is federally certified as a home health agency and duly licensed by the appropriate licensing authority to provide nursing and other therapeutic services.
2. Its policies are established by a professional group associated with such agency or organization, including at least one Physician and at least one Registered Nurse, to govern the services provided.
3. It provides for full-time supervision of such services by a Physician or by a Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an administrator.

Home health care shall consist of, but shall not be limited to, the following:

1. Part-time or intermittent nursing care by a Registered Nurse or by a licensed practical nurse under the supervision of a Registered Nurse, if the services of a Registered Nurse are not available;
2. Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a Registered Nurse or licensed practical nurse;
3. Physical, occupational or speech therapy;
4. Medical supplies, drugs and medicines prescribed by a Physician and laboratory services to the extent such charges would have been covered under the Policy or contract if the Insured had remained or had been confined in the Hospital;
(5) Medical social services provided to or for the benefit of a covered person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live. “Medical social services” mean services rendered, under the direction of a Physician by a qualified social worker, including but not limited to:
(A) assessment of the social, psychological and family problems related to or arising out of such covered person’s illness and treatment;
(B) appropriate action and utilization of community resources to assist in resolving such problems;
(C) participation in the development of the overall plan of treatment for such Insured.
Benefits shall be subject to all other limitations and provisions of the policy.

**Benefits for Treatment of Tumors and Leukemia (Plan B Only)**

Benefits will be paid the same as any other Sickness for the surgical removal of tumors and for treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any non-dental prosthesis, including any maxillofacial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors and a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.

Benefits per policy year shall be at least $1,000 for the removal of any breast implant, $500 for the surgical removal of tumors, $500 for reconstructive surgery, $500 for outpatient chemotherapy and $300 for prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for prosthesis shall be at least $300 for each breast removed, and $350 for a wig.

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

**Benefits for Mammography and Comprehensive Ultrasound Screening (Plan A & B)**

Benefits will be paid the same as any other Covered Medical Expenses as shown on the Schedule of Benefits for mammographic examinations to any woman insured under this policy which are equal to the following requirements: 1) a baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and 2) a mammogram every year for any woman who is forty years of age or older.

Additional benefits will be provided for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman’s Physician or advanced practice Registered Nurse.

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

Additional benefits will be provided for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman’s Physician or advanced practice Registered Nurse.

Benefits shall be subject to all Deductible, copayments, coinsurance, limitations, or any other provisions of the policy.
Benefits for Specialized Formulas (Plan B Only)

Benefits shall be provided for Medically Necessary specialized formulas for Dependent children up to age eight when such specialized formulas are for the treatment of a Sickness or condition for which newborn screening is required under section 19a-55 of the Public Health and Well Being Regulation.

"Specialized formula" means a nutritional formula for children up to age eight that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific Sicknesses.

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

Benefits for Infertility Treatment (Plan B Only)

Benefits will be paid the same as any other Sickness for an Insured Person for the medically necessary expenses of the diagnosis and treatment of Infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. Such infertility treatment must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

For the purposes of this section “Infertility” means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period.

Benefits are subject to the following limitations:

1) Benefits are available up to the Insured Person’s fortieth (40) birthday.
2) Benefits for ovulation induction are subject to a lifetime limit of four (4) cycles.
3) Benefits for intrauterine insemination are subject to a lifetime limit of three (3) cycles.
4) Benefits for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer, and low tubal ovum transfer are subject to a lifetime limit of two (2) cycles, with not more than two (2) embryo implantations per cycle.
5) Benefits for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer are payable only to those Insured Persons who:
   a) Have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered by this policy. However benefits will not be denied on this basis for any Insured Person who forgoes a particular infertility treatment or procedure if the Insured Person’s Physician determines that such treatment or procedure is likely to be unsuccessful.
   b) Have been covered under the school’s student insurance policy for at least 12 months.
   c) Provide disclosure of any previous infertility treatment or procedures for which such Insured Person received coverage under a different health insurance policy.

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

Benefits for Ostomy Appliances and Supplies (Plan B Only)

Benefits will be paid for the Usual and Customary Charges for Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors up to a maximum benefit of $1,000.00 per Policy Year.

"Ostomy" shall include colostomy, ileostomy and urostomy.

Benefits shall be subject to all Deductible, copayments, coinsurance, limitations, or any other provisions of the policy.
Benefits for Diabetes (Plan B Only)

Benefits will be paid the same as any other Sickness for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include Medically Necessary equipment, in accordance with the Insured Person's treatment plan, drugs and supplies prescribed by a Physician.

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

Benefits for Early Intervention Services (Plan B Only)

Benefits will be paid the same as any other Sickness for Medically Necessary Early Intervention Services for Dependent Eligible Children that are provided as part of an Individualized Family Service Plan pursuant to Title 17a of the Social and Human Services and Resources, Chapter 319b, Department of Mental Retardation, section, 17a-248e, up to a maximum benefit of $5,000.00 per calendar year. Benefits paid under this benefit shall not be applied to any maximum lifetime or Policy Year maximum specified in the Policy. "Early intervention services" means early intervention services, as defined in 34 CFR Part 303.12, as from time to time amended. "Eligible children" means Dependent children from birth to thirty-six months of age, who are not eligible for special education and related services pursuant to sections 10-76a to 10-76h, inclusive, as amended, and who need Early Intervention Services because such children are: (A) Experiencing a significant developmental delay as measured by standardized diagnostic instruments and procedures, including informed clinical opinion, in one or more of the following areas: (1) cognitive development; (2) physical development, including vision or hearing; (3) communication development; (4) social or emotional development; or (5) adaptive skills; or (B) Diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay. "Individualized family service plan" means a written plan for providing Early Intervention Services to an Eligible Child and the child’s family after completion of an evaluation.

"Evaluation" means a multidisciplinary professional, objective assessment conducted by appropriately qualified personnel in order to determine a child's eligibility for Early Intervention Services.

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

Benefits for Postpartum Care (Plan A&B)

If an Insured and Newborn Infant are discharged from inpatient care less than forty-eight hours after a vaginal delivery or less than ninety-six hours after a cesarean delivery, benefits will be provided on the same basis as any other Covered Medical Expense for a follow-up visit within forty-eight hours of discharge and an additional follow-up visit within seven days of discharge. Any decision to shorten the length of inpatient stay to less than forty-eight hours after a vaginal delivery or ninety-six hours after a cesarean delivery shall be made by the Physician after conferring with the Insured.

Follow-up services shall include, but not be limited to, physical assessment of the Newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any Medically Necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and Newborn pediatric care.

Benefits shall be subject to all Deductible, copayments, coinsurance, limitations, or any other provisions of the policy.
Benefits for Mental or Nervous Conditions (Plan B Only)

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Mental or Nervous Conditions.

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

Benefits for Isolation Care and Emergency Care (Plan A&B)

Benefits will be paid the same as any other Injury or Sickness for isolation care and emergency services provided by the state’s critical access Hospital.

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

Benefits for Hearing Aids for Children (Plan B Only)

Benefits will be paid the same as any other Sickness for Medically Necessary hearing aids for Dependent children ages twelve years or younger up to a maximum benefit of $1000 within a twenty-four month period.

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

Benefits for Prostate Cancer Testing (Plan B Only)

Benefits will be paid the same as any other Sickness for laboratory and diagnostic tests, including, but not limited to, prostate specific antigen (PSA) tests to screen for prostate cancer for Insureds who are symptomatic, whose biological father or brother has been diagnosed with prostate cancer, and for all Insureds fifty (50) years of age or older.

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

Benefits for Colorectal Cancer Screening (Plan B Only)

Benefits will be paid the same as any other Sickness for colorectal cancer screening, including, but not limited to: (1) an annual fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American College of Gastroenterology, after their consultation with the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations.

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

Benefits for Cancer Clinical Trial (Plan B Only)

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.

Benefits are subject to all Deductible, copayment, terms, conditions, restrictions, Exclusions and Limitations 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 Reconstructive Breast Surgery (Plan B Only)

Benefits will be paid for the Usual and Customary Charges incurred for reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Benefits shall be subject to all Deductible, copayments, coinsurance, limitations, or any other provisions of the policy.
Benefits will be paid the same as any other Sickness for physical therapy, speech therapy, and occupational therapy services for the treatment of Autism Spectrum Disorders, as set forth in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders”.

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

**Definitions**

- **Injury** means accidental bodily injuries sustained by the Insured Person which: 1) are the direct cause, independent of disease or bodily infirmity or any other cause; 2) are treated by a Physician within 30 days after the date of accident; and occurs while this policy is in force, subject to the policy Pre-existing Condition provisions. 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, subject to the policy Pre-existing Condition provisions.

- **Pre-existing Condition** means any condition which is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured’s Effective Date under the policy. Under Plan B (Policy 2009-201337-2) routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a pre-existing condition.

- **SICKNESS** means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy, subject to the policy Pre-existing Condition provisions. 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 Plan B.

- **TOTALLY DISABLED** means a condition of a Named Insured which, because of Sickness or Injury, renders the 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 Plan A 2009-201337-1**

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. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
2. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;
3. 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;
4. Dental treatment, except as specifically provided in the Policy;
5. Elective Surgery or Elective Treatment;
6. 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;

7. Immunizations, preventive medicines or vaccines, except where required for treatment of a covered Injury;

8. Injury for which benefits are paid or payable under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation;

9. 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;

10. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician’s release for rehabilitation;

11. Participation in a riot, civil disorder or a felony. Participation means to voluntarily take a part or share with others assembled together in some activity. Riot means a violent public disturbance of the peace by a number of persons assembled together;

12. Pre-existing Conditions for a period of 12 months, except for individuals who have been continuously insured under the school’s student insurance policy for at least 12 consecutive months. Credit will be given for Pre-existing Conditions for (a) newly Insured Persons who were covered under Previous Qualifying Coverage, but not covered for such Pre-existing Conditions under the Qualifying Coverage when (a) the preceding Qualifying Coverage which was continuous to a date not less than 120 days prior to their effective date under this policy; and for (b) newly Insured Persons who apply within 30 days of initial eligibility under this policy and whose previous Qualifying Coverage was terminated due to the involuntary loss of employment and was continuous to a date not more than 150 days prior to their effective date under this policy. This Pre-existing Condition Limitation will not apply to newly Insured Persons who were covered for such Pre-existing Conditions, under Qualifying Coverage when (a) the preceding Qualifying Coverage was continuous to a date not less than 120 days prior to their effective date under this policy; or (b) newly Insured Persons who apply within 30 days of initial eligibility under this policy and whose previous Qualifying Coverage was terminated due to the involuntary loss of employment and was continuous to a date not more than 150 days prior to their effective date under this policy;

13. Prescription Drugs dispensed or purchased while not Hospital Confined;

14. Services provided without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee for which the Insured is not charged;

15. Sickness or disease in any form;

16. Skydiving, parachuting, hang gliding, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

17. Injury resulting from suicide or attempted suicide while sane or insane; or intentionally self-inflicted Injury;

18. Supplies, except as specifically provided in the policy;

19. Treatment in a Government hospital for which the Insured is not charged, unless there is a legal obligation for the Insured Person to pay for such treatment; and

20. 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).
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. Injections, except as specifically provided in the Benefits for Preventive Pediatric Care;
2. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
3. 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;
4. 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;
5. Dental treatment, except as specifically provided in the Policy;
6. Elective Surgery or Elective Treatment;
7. Elective abortion;
8. 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;
9. 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;
10. Hearing examinations or hearing aids, except as specifically provided in the Benefits for Hearing Aids for Children;
11. Immunizations, except as specifically provided in the Benefits for Preventive Pediatric Care; preventive medicines or vaccines, except where required for treatment of a covered Injury;
12. Injury or Sickness for which benefits are paid or payable under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation;
13. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
14. 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;
15. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician’s release for rehabilitation;
16. Participation in a riot, civil disorder or a felony. Participation means to voluntarily take a part or share with others assembled together in some activity. Riot means a violent public disturbance of the peace by a number of persons assembled together;
17. Pre-existing Conditions for a period of 12 months, except for individuals who have been continuously insured under the school’s student insurance policy for at least 12 consecutive months. Credit will be given for Pre-existing Conditions for (a) newly Insured Persons who were covered under Previous Qualifying Coverage , but not covered for such Pre-existing Conditions under the Qualifying Coverage when (a) the preceding Qualifying Coverage which was continuous to a date not less than 120 days prior to their effective date under this policy; and for (b) newly Insured Persons who apply within 30 days of initial eligibility under this policy and whose previous Qualifying Coverage was terminated due to the involuntary loss of employment and was continuous to a date not more than 150 days prior to their effective date under this policy. This Pre-existing Condition Limitation will not apply to newly Insured Persons who were covered for such Pre-existing Conditions, under Qualifying Coverage when (a) the preceding Qualifying Coverage was continuous to a date not less than 120 days prior to their effective date under this policy; or (b) newly Insured Persons who apply within 30 days of initial eligibility under this policy and whose previous Qualifying Coverage was terminated due to the involuntary loss of employment and was continuous to a date not more than 150 days prior to their effective date under this policy;
18. Prescription Drugs dispensed or purchased while not Hospital Confined;
19. 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, except as specifically provided in the Benefits for Infertility Treatment; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
20. 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;
21. 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;
22. Services provided without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee for which the Insured is not charged;
23. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except as specifically provided in the Benefits for Treatment of Craniofacial Disorder; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery;
24. Skydiving, parachuting, hang gliding, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
25. Unless specifically covered under Benefits for Mental or Nervous Conditions, Injury resulting from suicide or attempted suicide while sane or insane; or intentionally self-inflicted Injury;
26. Supplies, except as specifically provided in the policy;
27. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Benefits for Reconstructive Breast Surgery;
28. Treatment in a Government hospital for which the Insured is not charged, unless there is a legal obligation for the Insured Person to pay for such treatment; and
29. 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).
The Insurer will furnish the Insured the necessary forms for filing proof of loss. Claim forms may be obtained at the Company, P.O. Box 809025, Dallas, Texas 75380-9025.

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 Person shall be deemed to have complied with the requirements as to the proof of loss upon submitting to the Insured within 90 days written proof covering the occurrence, character and extent of the loss for which claim is made.

Written proof of loss must be submitted to the Company at P.O. Box 809025, Dallas, Texas 75380-9025 within 90 days after expense is incurred, or as soon thereafter as reasonably possible.

The Company, at its own expense, shall have the right and opportunity to examine the Insured as often as it may reasonably require and also may make an autopsy in case of death if not prohibited by law. 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 been obligated to pay 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.

All benefits payable under the Policy will be paid upon receipt of due written proof of loss. All benefits are payable to the Insured or his designated beneficiary or beneficiaries or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parents, guardian or other person actually supporting him. Subject to any written direction of the Insured, all or a portion of any benefits payable under the Policy may be paid directly to the Hospital, Physician or person rendering the service or treatment.

No action shall be brought under the Policy prior to the expiration of 60 days after filing written proof of loss and no action may be brought after 3 years from the date within which proof of loss is required by the Policy.
In the event of Injury or Sickness, students should:

1) Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.

2) School Time Injury Only Plan A – Secure a company claim form and cover letter from our website http://www.uhcsr.com/CCTC or from a school official. Fill out the form completely, attach all medical and hospital bills and fax the medical bills, cover letter and claim form to 469-229-5625 or mail to Student Insurance, Attn: ADA Claim Forms, PO Box 809025, Dallas TX, 75380-9025. Voluntary Sickness and Injury Plan B – 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) File claim within 30 days of Injury or first onset of Sickness. should must 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:

THE UNITED HEALTHCARE INSURANCE COMPANY

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

Online Services: Please visit our Websites www.uhcsr.com or www.uhcsr.com/college/viewbrochures.aspx for Certificates, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claim Status and other services.

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

This Certificate is based on Policy #’s
(Plan A) 2009-201337-1 and (Plan B) 2009-201337-2