

University of the District of Columbia

(“the Policyholder”)

Student Health Insurance

2010-2011

**Administrator Policy Number CHH0087181
Underwriter Reference Number CAS9499486**

*Underwritten by:
National Union Fire Insurance Company of
Pittsburgh, Pa. (“the Company”)*

ELIGIBILITY

PLAN I – DOMESTIC STUDENTS & PLAN II – INTERNATIONAL STUDENTS

All enrolled full-time students, part-time students and all international students are automatically enrolled in the University of the District of Columbia (UDC) Basic Student Health Insurance Plan. The premium for this coverage is added to the student’s tuition bill. Students who waive coverage with proof of comparable insurance coverage by the waiver deadline, will see the premium removed from their account.

Students who are currently insured under a comparable or better health policy (i.e., their own or through a family member) may waive out of the UDC Student Insurance Plan upon providing proof of other comparable insurance by submitting an online waiver. The waiver provided online must be completed by the last day of the waiver deadline. If the deadline is ignored, the student will be responsible for the insurance premium. Please see page 2 of this brochure for the waiver process and deadlines.

A student, who initially waived coverage under the Policy, but subsequently experiences ineligibility under another plan, may elect to enroll for coverage under the Policy within 31 days of the date of ineligibility under another comparable plan.

Plan III – Optional Supplemental Accident & Sickness Expense Benefit

This coverage is optional and may be purchased at an additional cost and is available to students only. It is available only to those students enrolled in the UDC Basic Student Health Insurance Plan (PLAN I). This coverage must be purchased simultaneously with the Basic Student Health Insurance Plan (PLAN I).

Eligibility requirements must be met each time a premium is paid. The Company maintains the right to investigate student status and attendance records to verify that Policy eligibility requirements have been and continue to be met. If the Company discovers that the eligibility requirements have not been or are not being met, its only obligation is refund of premium less any claims paid.

DEPENDENTS

A Covered Student enrolled in the UDC Basic Student Health Insurance Plan may obtain coverage for their Dependent Spouse and/or Dependent Child(ren) under the

age of 19. The Dependent enrollment forms are available online at www.maksin.com/udc.aspx. Dependents must enroll for the same term of coverage for which the Covered Students enrolls. An eligible student may enroll for coverage for his or her Dependents only during the first 30 days of the Policy term, or within 31 days of marriage, birth, or adoption, for which proof is required.

WAIVER PROCESS/PROCEDURE

Students, who are currently insured by a health insurance policy, may waive out of the UDC Basic Student Health Insurance Plan with proof of comparable coverage. The waiver form must be completed online at www.maksin.com/udc.aspx. Online waivers must be completed by the waiver deadline (see below). Failure to meet the waiver deadline will result in the student being responsible for the insurance premium.

Waiver Deadlines

Annual	September 1, 2010
Spring Semester*	January 26, 2011

(*Spring Semester available only to new students to the University)

PLEASE NOTE: All waiver information will be verified with your insurance company as part of the insurance verification process. If insurance status cannot be verified, the waiver will be revoked and the insurance premium will be charged to your student account.

PREMIUM RATES

	PLAN I		PLAN II	
	DOMESTIC STUDENTS		INTERNATIONAL STUDENTS	
	ANNUAL	SPRING/SUMMER*	ANNUAL	SPRING/SUMMER*
	08/01/10-07/31/11	01/01/11-07/31/11	08/01/10-07/31/11	01/01/11-07/31/11
Student	\$166	\$110	\$550	\$375
Spouse	\$885	\$584	\$1,650	\$1,125
Child	\$525	\$347	\$900	\$615
PLAN III**	\$340	\$340	N/A	N/A
Enrollment Deadline for Dependents	08/31/10	01/31/11	08/31/10	01/31/11

*SPRING/SUMMER - Only for new students to the University
 **Students only are eligible to purchase Plan III.

NOTE: For new students only enrolling for the Summer Session, Summer I Session or Summer II Session, please visit the webpage at www.maksin.com/udc.aspx for dates of coverage, waiver deadlines, premiums and dependent enrollment forms.

Extension of Benefits After Termination

If a Covered Person is Totally Disabled on the date his insurance ends, the term Eligible Expenses will include charges incurred after the date such insurance ends. Eligible Expenses for such Injury or Sickness will continue to be paid as long as the condition that caused the Total Disability continues but not to exceed 90 days after the date such insurance ends, subject to any maximum amounts.

Certificate of Creditable Coverage

Your coverage under this health plan is “creditable coverage” under Federal Law. When your coverage terminates, you can request a Certificate of Creditable Coverage, which is evidence of your coverage under this health plan. You may need such a Certificate if you become covered under a group health plan or other health plan within 63 days after your coverage under this health plan terminates. If the subsequent health plan excludes or limits coverage for medical conditions you have before you enroll, this Certificate may be used to reduce or eliminate those exclusions or limitations.

In order to obtain a Certificate of Creditable Coverage, please contact:

The Maksin Group
Two Aquarium Drive, Suite 200
Camden, New Jersey 08103
1-800-220-1123

EXCESS PROVISION

Benefits payable for the Eligible Expenses under this provision will be limited to that part of the Eligible Expense, if any, which is in excess of the total benefits payable for the same Injury or Sickness, on a provision of service basis or on an expense incurred basis under any Other Valid and Collectible Group Insurance. If the Other Valid and Collectible Group Insurance provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose policy or service contract has been in effect for the longer period of time at the date of such Injury or Sickness.

For purposes of this Policy, a Covered Person’s entitlement to Other Valid and Collectible Group Insurance will be determined as if this Policy did not exist and will not depend on whether timely application for benefits from Other Valid and Collectible Group Insurance is made by or on behalf of the Covered Person.

Benefits under this Policy will be reduced to the extent that benefits for Expenses are covered by any Other Valid and Collectible Group Insurance whether or not a claim is made for such benefits.

Benefits for Accidental Death, Dismemberment, or Loss of Sight

If, within one year from the date of an accident covered by the Policy, Injury from such accident, results in Loss listed below, we will pay the benefit set opposite such Loss. If the Covered Person sustains more than one such Loss as the result of one accident, we will pay only one amount, the largest to which he is entitled.

For Loss Of:

Life	\$2,000
Two or More Members	\$2,000
One Member.....	\$1,000
Thumb and Index Finger of the Same Hand.....	\$500

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight of an eye means total irrecoverable loss of the entire sight of that eye. Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

“Severance” means the complete separation and dismemberment of the part from the body. “Member” means hand, foot or eye.

PREFERRED PROVIDER INFORMATION

In an effort to control insurance medical costs and enhance payment, this plan has implemented a Preferred Provider Organization (PPO) of Hospitals, Clinics and Doctors who are willing to provide services at negotiated lower rates to Covered Persons eligible for benefits. The use of this PPO may reduce the Covered Person’s out-of-pocket expenses. You can obtain a listing of participating providers at www.phcs.com or by calling the PHCS Network at 1-866-680-7427. International students, please note the in-network and out-of-network benefits on the Schedule of Benefits.

REPATRIATION OF REMAINS BENEFIT

If a Covered Person suffers loss of life due to Injury or Sickness while outside his or her home country, the Company will pay for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding a Maximum Amount of \$10,000 per Covered Person. Eligible Expenses include, but are not limited to: (1) embalming or

cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible. The Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Company in advance.

MEDICAL EVACUATION EXPENSE

The Company will pay for Eligible Medical Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or Sickness that warrants his or her Medical Evacuation while outside his or her home country, but not exceeding the Maximum Amount of \$10,000 per Covered Person. The Doctor ordering the Medical Evacuation must certify that the severity of the Covered Person's Injury or Sickness warrants his or her Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible. The Company must make all arrangements and must authorize all expenses in advance for any Medical Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact the Company in advance. Benefits will be considered only after being hospitalized for at least five (5) consecutive days.

Mandated Benefits

District of Columbia mandates coverage for the following benefits: Diabetes; Mammography and Cytological Screening; Colorectal Screening; Breast Cancer Treatment; Reconstructive Breast Surgery; Prostate Cancer Screening; Child Health Supervision Services; Emergency Department HIV Screening Test; Substance Abuse and Mental Illness; Coverage For Hormone Replacement Therapy; and Clinical Trials. Please see the Policy on file with the Policyholder for complete details.

DEFINITIONS

"Accident" means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

"Allowable Charges" means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

"Covered Person" means a Covered Student while coverage under the Policy is in effect and those Dependents with respect to whom a Covered Student is insured.

"Deductible/Deductible Amount" means the dollar amount of Eligible Expenses a Covered Person must pay before benefits become payable.

"Dependent" means (a) the Covered Student's Spouse residing with the Covered Student, and (b) the Covered Student's unmarried child under age 19 if he is: (a) dependent upon the Covered Student for support; and (b) living in the household of the Covered Student, or (c) is a full-time student as defined by the school he or she attends.

The term "child" includes: (a) a Covered Student's legally adopted child; (b) child who has been placed in the Covered Student's home pending adoption procedures; and (c) a Covered Student's step-child if such child resides with the Covered Student and depends on the Covered Student for full support.

"Elective Treatment" means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; botox injections; treatment of infertility and routine physical examinations.

"Eligible Expense" means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

"Emergency Medical Condition" means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of medicine and health, to result in: (a) placing the health or pregnancy of the person afflicted with such condition in serious

jeopardy; (b) serious impairment to such person's bodily functions; (c) serious impairment or dysfunction of any bodily organ or part of such person.

“Hospital” means a facility which meets all of these tests: (a) it provides in-patient services for the care and treatment of injured and sick people; and (b) it provides room and board services and nursing services 24 hours a day; and (c) it has established facilities for diagnosis and major surgery; and (d) it is supervised by a Doctor; and (e) it is run as a Hospital under the laws of the jurisdiction which it is located; and (f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders; or substance abuse. The term “Hospital” includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; (c) a mental health hospital if supervised and licensed by the Department of Mental Health; and (d) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person's effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

“Medical Necessity/Medically Necessary” means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is Experimental/Investigational or for research purposes; or

(e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment. The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

“Pre-Existing Condition” means a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the 6 months prior to the Covered Person's effective date of coverage under the Policy.

“Reasonable and Customary” means the charge which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

“Geographic area” means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date shown in the Schedule of Benefits.

“Sickness” means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered One Sickness.

“Totally Disabled” and “Total Disability” means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a student: from attending classes at the location where he or she is enrolled; and (b) with respect to a Dependent, or a student if such classes are not in session, from doing those activities that are normal for a person in good health of the same age and sex with respect to a Dependent, Hospital Confinement.

SCHEDULE OF BENEFITS

DOMESTIC – PLAN I

Basic Plan Aggregate Maximum Benefit	\$25,000 Per Injury or Sickness Per Policy Year
Deductible	See Outpatient Miscellaneous Expenses
Eligible Expenses include:	
INPATIENT	
Room & Board , average daily semi-private room rate; and general nursing care provided by the Hospital	R&C up to \$700 maximum per day
Hospital Miscellaneous , such as cost of operating room, laboratory tests and x-ray (including professional fees), anesthesia, drugs (excluding take-home drugs) or medicines, pre-admissions testing, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admissions will be counted, but not the day of discharge	R&C up to \$600 first day / \$500 second day / \$400 each subsequent day
Physiotherapy	Paid under Hospital Miscellaneous
Surgery , no more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.	\$150 surgical factor times unit value
Assistant Surgeon	20% of surgery allowance
Anesthesia	25% of surgery allowance
Registered Nurse , private duty nursing care	Injury: R&C Sickness: R&C up to \$75 per day
Doctor's Visits , benefits are limited to one visit per day and do not apply when related to surgery	R&C
Substance Abuse/Mental Illness Expense	Paid as any other Sickness up to \$5,000 maximum per Policy Year
<ul style="list-style-type: none"> • Substance Abuse Dependency is limited to not more than 12 days of detoxification treatment per Policy Year, and not more than 28 days of treatment in a residential treatment facility or hospital. • Mental Illness is limited to not more than 45 days per Policy Year in a residential facility or hospital. 	
OUTPATIENT	
Surgery , no more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.	80% up to a maximum of \$2,000
Day Surgery Miscellaneous , related to a scheduled surgery performed in a Hospital or outpatient facility, including the cost of the operating room, laboratory tests and x-rays (including professional fees), anesthesia drugs (excluding take-home drugs) or medicines, and supplies. Reasonable & Customary charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	R&C up to \$1,000 maximum per Injury or Sickness
Anesthesia	25% of surgery allowance
Outpatient Miscellaneous Expenses , including all benefits designated as "Paid under Outpatient Misc."	After the \$50 deductible per Injury or Sickness (maximum of two Deductibles per Policy Year) R&C up to a \$2,000 maximum per Injury or Sickness
Doctor's Visits , one visit per day and do not apply when related to surgery.	Injury: R&C – Sickness: \$50 per visit/up to \$1,000 maximum per Sickness
Physiotherapy , one visit per day	Injury: R&C – Sickness: Paid under Doctor's Visits
Emergency Medical Condition , for use of Hospital Emergency Room, including attending doctor's charges, operating room, laboratory and x-ray examinations, injections and supplies.	Paid under Outpatient Miscellaneous
X-Ray & Laboratory , deductible does not apply	Paid under Outpatient Miscellaneous
Radiation Therapy and Chemotherapy	Paid under Outpatient Miscellaneous
Tests & Procedures , (diagnostic services and medical procedures performed by the doctor, other doctor's visits, physiotherapy, x-rays and lab procedures)	Paid under Outpatient Miscellaneous
Injections , when administered in the doctor's office	Paid under Outpatient Miscellaneous
Prescription Drugs , must be expensed at a participating Express Scripts pharmacy. A complete listing of Express Scripts participating pharmacies can be obtained by visiting the University of the District of Columbia webpage at www.maksin.com . However obtained, all prescription drugs are subject to the aggregate maximum amount per Policy Year.	After a \$10 copay for generic drugs or \$25 copay for brand name drugs, up to \$400 aggregate maximum per Policy Year (all conditions combined)
Psychotherapy , All Eligible Expenses incurred as a result of a Substance Abuse/Mental Illness are subject to the maximum including prescription drugs and diagnostic testing.	50% up to \$75 per day; \$1,000 maximum per Policy Year
CAT Scan / MRI	Paid under Outpatient Miscellaneous
OTHER	
Ambulance	Injury: R&C; Sickness: R&C up to \$175 maximum per Sickness
Durable Medical Equipment/Braces & Appliances , only upon a doctor's written prescription. Replacement braces and appliances are not covered.	Injury: R&C; Sickness: no benefit
Consultant , when requested and approved by the attending doctor,	Injury: R&C; Sickness: R&C up to \$100 maximum per Sickness
Dental – Injury , to sound natural teeth	Injury: R&C to \$1,000 maximum per tooth; Sickness: No Benefit
Maternity Benefits	Paid the same as any other Sickness
Elective Abortion	R&C up to \$150 maximum

PLAN III: OPTIONAL SUPPLEMENTAL ACCIDENT AND SICKNESS EXPENSE BENEFIT

(For Students Enrolled in Plan I Only - additional premium required) **\$50,000 Maximum Benefit Per Injury or Sickness Per Policy Year**

If elected by the Covered Student during initial enrollment and the appropriate premium is paid, the Supplemental Accident and Sickness Expense Benefit will begin payment after the Basic Plan maximum benefit of \$25,000 per Injury or Sickness has been paid and a \$100 deductible per Injury or Sickness has been met. Thereafter the Company will pay 80% of R&C charges for additional Eligible Expenses incurred up to the Supplemental Accident and Sickness Expense Benefit Maximum of \$25,000 per Injury or Sickness. The combined maximum benefit payable for Basic and Supplemental Accident and Sickness Expense Benefits is \$50,000 per Injury or Sickness. The following Eligible Expenses will be paid: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthesiologist; (e) inpatient and outpatient Doctor visits; (f) consultant; (g) hospital outpatient department; (h) emergency room; (i) diagnostic x-ray and laboratory tests; (j) durable medical equipment, braces and appliances; and (k) other expenses incurred for the treatment of an Injury or Sickness.

Any charges incurred for an Injury sustained or a Sickness that began prior to the Covered Student's effective date of coverage under the Optional Supplemental Accident and Sickness Expense Benefit will not be Eligible Expenses for purposes of benefit payment for the first 12 months following the effective date of Optional Supplemental Accident and Sickness Expense Benefit coverage under the Policy.

SCHEDULE OF BENEFITS

Basic Plan Aggregate Maximum Benefit	INTERNATIONAL – PLAN II
Deductible	\$5,000 Per Injury or Sickness Per Policy Year
Eligible Expenses include:	\$100 Per Injury or Sickness Per Policy Year
INPATIENT	
Room & Board , average daily semi-private room rate; and general nursing care provided by the Hospital	R&C up to \$500 maximum per day
Hospital Miscellaneous , such as cost of operating room, laboratory tests and x-ray (including professional fees), anesthesia, drugs (excluding take-home drugs) or medicines, pre-admissions testing, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admissions will be counted, but not the day of discharge	R&C
Physiotherapy	Paid under Hospital Miscellaneous
Surgery , no more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.	R&C
Assistant Surgeon	20% of surgery allowance
Anesthesia	25% of surgery allowance
Registered Nurse , private duty nursing care	R&C
Doctor's Visits , benefits are limited to one visit per day and do not apply when related to surgery	R&C
Substance Abuse/Mental Illness Expense	R&C up to \$5,000 maximum
<ul style="list-style-type: none"> • Substance Abuse Dependency is limited to not more than 12 days of detoxification treatment per Policy Year, and not more than 28 days of treatment in a residential treatment facility or hospital. • Mental Illness is limited to not more than 45 days per Policy Year in a residential facility or hospital. 	
OUTPATIENT	
Surgery , no more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.	R&C
Day Surgery Miscellaneous , related to a scheduled surgery performed in a Hospital or outpatient facility, including the cost of the operating room, laboratory tests and x-rays (including professional fees), anesthesia drugs (excluding take-home drugs) or medicines, and supplies. Reasonable & Customary charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	R&C
Anesthesia	25% of surgery allowance
Outpatient Miscellaneous Expenses , including all benefits designated as "Paid under Outpatient Misc."	R&C up to \$2,500 maximum per Injury or Sickness
Doctor's Visits , one visit per day and do not apply when related to surgery.	After a \$10 copay per visit up to \$75 maximum per Injury or Sickness
Physiotherapy , one visit per day	Injury: R&C – Sickness: paid under Doctor Visits
Emergency Medical Condition , for use of Hospital Emergency Room, including attending doctor's charges, operating room, laboratory and x-ray examinations, injections and supplies.	After a \$100 copay per visit
X-Ray & Laboratory , deductible does not apply	After a \$10 copay per visit, paid under Outpatient Miscellaneous
Radiation Therapy and Chemotherapy	After a \$10 copay per visit, paid under Outpatient Miscellaneous
Tests & Procedures , (diagnostic services and medical procedures performed by the doctor, other doctor's visits, physiotherapy, x-rays and lab procedures)	After a \$10 copay per visit, paid under Outpatient Miscellaneous
Injections , when administered in the doctor's office	After a \$10 copay per visit, paid under Outpatient Miscellaneous
Prescription Drugs , limited to a 30 day supply per prescription. However obtained, all prescription drugs are subject to the aggregate maximum amount per Policy Year.	50% of R&C up to \$500 aggregate maximum per Policy Year (all conditions combined)
Psychotherapy . All Eligible Expenses incurred as a result of a Substance Abuse/Mental Illness are subject to the maximum including prescription drugs and diagnostic testing.	Paid as in coinsurance; \$75 per visit maximum; \$5,000 maximum per Policy Year
CAT Scan / MRI	R&C
OTHER	
Ambulance	R&C
Durable Medical Equipment/Braces & Appliances , only upon a doctor's written prescription. Replacement braces and appliances are not covered.	R&C
Consultant , when requested and approved by the attending doctor.	R&C
Dental – Injury , to sound natural teeth	Accident: R&C up to to \$250 maximum per tooth; Sickness: No Benefit
Maternity Benefits	Paid the same as any other Sickness
Elective Abortion	R&C up to \$150 maximum

MAJOR MEDICAL EXPENSE BENEFIT

The Major Medical Expense Benefit will begin payment after the Basic Plan maximum benefit of \$5,000 per Injury or Sickness has been paid. Thereafter the Company will pay 80% of Allowable Charges in-network or 60% of R&C charges out-of-network for additional Eligible Expenses incurred up to the Major Medical Expense Benefit Maximum of \$45,000 per Injury or Sickness. The combined maximum benefit payable for Basic and Major Medical Expense Benefits is \$50,000 per Injury or Sickness.

The following Eligible Expenses will be paid: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) consultant; (g) hospital outpatient department; (h) emergency room; (i) diagnostic x-ray and laboratory tests; (j) durable medical equipment, braces and appliances; and (k) other expenses incurred for the treatment of an Injury or Sickness.

EXCLUSIONS

The Policy does not cover nor provide benefits for loss or expenses incurred:

1. as a result of dental treatment, or dental x-rays except for treatment resulting from Injury to sound, natural teeth.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Service fee.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such; hearing aids; orthodontic braces and orthodontic appliances or prescriptions or examinations for such.
4. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
5. for Injury or Sickness resulting from war or act of war, declared or undeclared.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
10. for preventive treatment, testing, medicines, serums, vaccines, or vitamins except as specifically provided in the Policy.
11. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, or insurrection.
12. for elective treatment or elective surgery.
13. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
14. for any services rendered by a Covered Person's immediate family member.
15. for a treatment, service or supply which is not Medically Necessary.
16. as a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
17. for treatment of temporomandibular joint dysfunction.
18. for treatment of mental or nervous disorders except as specifically provided in the Policy.
19. for Injury due to being legally intoxicated, as defined by the jurisdiction in which an Accident occurs, while operating a motor vehicle.
20. for Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Doctor.
21. for surgery and/or treatment of: acne; gynecomastia; allergy, including allergy testing; biofeedback-type services; circumcision; corns, calluses and bunions; deviated nasal septum, including submucuous resection and/or other surgical correction thereof except for purulent sinusitis; family planning; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; learning disabilities; nonmalignant warts, moles and lesions; sexual reassignment surgery and related therapy; sleep disorders, including supplies, treatment and testing thereof; preventive medicines or vaccines, except where required for the treatment of Injury; tubal ligation; vasectomy; alopecia; and weight reduction.
22. for routine physical examinations, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in the Policy.
23. as a result of a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place, except in a Driver's Education Program.
24. for elective sterilization or its reversal, artificial insemination or in vitro fertilization.

25. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle and/or off-road four wheeled motorized vehicles).
26. for organ transplants.
27. for outpatient physiotherapy except for a condition that required surgery or Hospital Confinement: (1) within 30 days immediately preceding such physiotherapy; or (2) within 30 days immediately following the attending doctor's release for rehabilitation.
28. for Injury resulting from: the practicing for, participating in interscholastic, intercollegiate, club, or professional sports activity, including travel to and from the activity and practice; scuba diving; hang gliding; parasailing; sky diving; flight in an ultra light aircraft; glider flying; sail planing; parachuting; bungee jumping; or ballooning.
29. for rest cures or custodial care.
30. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
31. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
32. for home health care.

PRE-EXISTING CONDITIONS: Expenses incurred by a Covered Person as a result of a Pre-existing Condition will not be considered Eligible Expenses for a period of twelve months of continuous coverage while covered under this Policy.

This limitation will not apply if, during the period immediately preceding the Covered Person's effective date of coverage under this Policy, the Covered Person was covered under prior Creditable Coverage for 12 consecutive months. Prior Creditable Coverage of less than 12 months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Condition limitation will apply only if the Covered Person becomes eligible and enrolls for coverage within 63 days of termination of his or her prior coverage.

**AMERICAN HEALTH HOLDING, INC.
24-HOUR STUDENT EMERGENCY CARE HOTLINE
(American Health Holding, Inc. is not affiliated
with National Union Fire Insurance Company
of Pittsburgh, Pa.)**

For confidential health care advice and information, 24 hours a day, 365 days a year, call toll-free 866-315-8756.

- **Comprehensive Resources and Advice from Registered Nurses**
- Direct access to an extensive Health Information Library, covering issues ranging from women's health to pediatrics. Detailed directories with topic codes and instructions for access to health-related topics.
- Choose to talk directly with a nurse. Discuss a current illness or health issue, or receive counseling on chronic conditions. Nurses can also educate callers about treatments, lifestyle choices and self-care strategies.
- Integrated phone access to specially trained personnel, trained to provide referral services for a number of health related concerns including mental health and/or substance abuse.

Travel Guard

Procedures on How to Access Travel Guard 24-hour Assistance Call Center

How to Contact Travel Guard:

- Inside the US and Canada, dial 1-877-249-5362 toll-free.
- Outside the US and Canada:
 - Request an international operator.
 - Request the operator to place a collect call to the USA at 715-295-9625.
- Our fax number is 01-713-974-3422.

When to Contact Travel Guard:

- Call Travel Guard when you require medical assistance or have a medical emergency.
- Call Travel Guard for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Guard whenever there is a question.

Travel Guard is available 24-hours-a-day/7-days-a-week/
365-days-a-year.

Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help you should the need arise while you are traveling or away from home.

The Travel Guard Services Medical Staff consists of full-time, onsite Registered Nurses and Emergency Physicians who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a physician has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide to Travel Guard when you call:

- Advise Travel Guard who you are insured by.
- Provide your Policy number.
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

Description of Services

Information/General: These services include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency exchange rates, local Bank/Government holidays, and, by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage & relay and translation services.

- Visa & Immunization
- Weather & Exchange Rates
- Environmental & Political Warnings

Technical: These services provide assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers & vehicle return in the event of illness or accident, provide legal referrals, and help with arrangements for members who encounter enroute emergencies that force them to interrupt their trips.

- Legal Referral
- Embassy/Consulate Information
- Lost/Stolen Luggage & Personal Effects Assistance
- Lost Document Assistance & Cash Transfer Assistance
- Enroute Travel Assistance
- Claims-related Assistance
- Telephone Interpretation

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard's Medical Staff in addition to other network

providers and often include post-case payment/billing coordination on the traveler's behalf. These services include physician/dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains, and insurance/claims coordination.

Medical Assistance:

- Medical Referral
- Out-patient Assistance
- In-patient Assistance

STUDENT ASSIST SERVICES

Concierge Services: You receive the comforts, care and attention of Student Assist's Personal Assistance Coordinators available 24/7 to respond to virtually any request – large or small.

Personal Security Assistance: You can feel safe and secure with Student Assist's Personal Security Assistance at home or while traveling. To activate personal security services, please log on to: www.chartisinsurance.com/us/security. For initial setup, your login is "9499486" and the password is "security."

Claim Procedure

In the event of Injury or Sickness, the student should:

1. Report at once to the Student Health Center for treatment or referral, or when not in school, to the nearest doctor or hospital.
2. Mail to the address below a completed Company claim form, all medical and hospital bills, along with the insured student's name, address, Student ID number and name of the college or university under which the student is insured.
3. File claim within 30 days of injury or first treatment for a sickness. bills must be received by the Company within 90 days of service to be considered for payment.

Insurance is Underwritten by:
**National Union Fire Insurance Company of
Pittsburgh, Pa.,
with its principal place of business in New York, NY**

Submit all Claims or Inquiries to:
**Maksin Management Corp.
P.O. Box 2647
Camden, NJ 08101-2647
(877) 775-5430**

NON-RENEWABLE ONE YEAR TERM INSURANCE

The Policy is a non-renewable one-year term Insurance. Similar coverage may be purchased for the following academic year. It is the insured's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new policy year.

**PLEASE VISIT THE WEBSITE AT WWW.MAKSIN.COM
TO LEARN ABOUT OPTIONAL DENTAL & VISION
DISCOUNT PLANS OFFERED ON A VOLUNTARY
BASIS FOR 2010-2011**

At The Maksin Group, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more information, please go to our website at www.maksin.com.

Please keep this brochure as a general summary of the insurance. This is only a brief description of the coverage available under policy series S30494NUFIC-DC. The Policy on file at the University may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this document and the Policy, the Policy shall govern.