

2009-2010

Blanket Student Accident and Sickness Insurance Plan

Especially designed for:

Hershey Medical Students



PENNSTATE



College of Medicine

**Non-Participating Non-Renewable One Year Term
This Policy Contains a Preferred Provider Provision**



UnitedHealthcare®
A UnitedHealth Group Company

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PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public 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 non-public personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-888-224-4810 or by visiting us at www.uhcsr.com.

ELIGIBILITY

All Hershey medical students are eligible to enroll in this insurance plan. Eligible Dependents of students enrolled in the plan may participate in the plan on a voluntary basis.

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

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet classes and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains the right to investigate student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse, Domestic Partner and unmarried children under 19 years of age or 23 years if a full-time student at an accredited institution of higher learning who are not self-supporting. See the Definition Section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Optional Coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment in the plan. Only those students enrolled in Basic coverage may purchase Optional Major Medical. Students may purchase optional coverage for themselves or for themselves and all family members.

ENROLLMENT DEADLINES

The deadlines for enrollment in this insurance Plan are as follows:

Fall	August 31, 2009
Spring/Summer	January 19, 2010
Summer Session	May 24, 2010

Application and premium must be received by the company or Penn State Student Health Insurance, 302 Student Health Center, University Park, 16802, on or before the enrollment deadline listed above. Premium received after these dates will be returned. **DATE OF POSTMARK DOES NOT FULFILL THIS REQUIREMENT.**

EFFECTIVE AND TERMINATION DATES

The Master Policy on file at the school becomes effective August 1, 2009. The Master Policy terminates August 1, 2010. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student. Coverage periods are as follows:

Medical Students

Annual	8-01-2009 to 8-01-2010
Fall	8-01-2009 to 1-01-2010
Spring/Summer	1-01-2010 to 8-01-2010
Summer	5-01-2010 to 8-01-2010

Refunds of premiums are allowed only upon entry into the armed forces.

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

RENEWAL OF PREMIUM

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 14 days after the coverage expiration date. It is the student's responsibility to make timely renewal payments to avoid a lapse in coverage.

PREMIUM RATES

	Students	Spouse or Domestic Partner	Each Child
Annual	\$1,107.00	\$4,015.00	\$1,777.00
Fall	\$ 472.00	\$1,712.00	\$ 758.00
Spring/Summer	\$ 657.00	\$2,384.00	\$1,055.00
Summer	\$ 228.00	\$ 830.00	\$ 368.00

Optional Major Medical is \$253 per insured, not prorated.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 12 months after the termination date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

PRE-ADMISSION NOTIFICATION

Avidyn should be notified of all Hospital Confinements prior to admission.

- 1. PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
- 2. NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide the notification of any admission due to Medical Emergency.

Avidyn is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

**THE PENN STATE STUDENT INJURY AND SICKNESS INSURANCE PLAN
FOR HERSHEY MEDICAL STUDENTS
2009-2010 SCHEDULE OF BASIC MEDICAL EXPENSE BENEFITS**

**Maximum Benefit Up To \$50,000 Paid as Specified Below (For Each Injury or Sickness)
\$50 Deductible (For Each Injury or Sickness)(Per Insured Person)
(Maximum cumulative Deductible Per Policy Year is \$150 per student and \$250 per family.)**

IMPORTANT: The Deductible will be waived and benefits will be paid for 100% of Covered Medical Expenses incurred when treatment is rendered at University Health Services (UHS) or Fishburn Clinic for Hershey Medical Students. Deductible will be waived for Laboratory charges at Centre Pathology when referred by the University Health Services.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. **If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits.** If the Covered Medical Expense is incurred due to Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used. **After the Deductible has been satisfied, Hospital Expenses and ICU/Hospital Expenses at Mt. Nittany Medical Center and the Milton S. Hershey Medical Center will be paid at 100% of Preferred Allowance excluding professional fees.** Warts, non-malignant moles and lesions are covered when treated by or referred by University Health Services or Fishburn Clinic.

Mandatory Immunization Requirements for all Medical Students are covered as necessary including: Measles (rubeola); Mumps; Rubella; Tetanus/diphtheria; Varicella (chickenpox); Tuberculosis test (Mantoux); Hepatitis B; Polio; and Meningitis vaccine.

All benefits are combined Preferred Provider and Out-of-Network, unless noted below.

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

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

	Preferred Providers	Out-of-Network Providers
INPATIENT		
Hospital Expense , \$1,800 maximum per day. Daily semi-private room rate; general nursing care provided by the Hospital. Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, 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.	100% of PA	80% of U&C
Intensive Care / Hospital Expense , \$2,100 maximum per day. Daily intensive care rate. Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	100% of PA	80% of U&C
Routine Newborn Care , 4 days Hospital Confinement Expense maximum. While Hospital Confined; and routine nursery care provided immediately after birth.	Paid as any other Sickness	Paid as any other Sickness
Physiotherapy	Paid under Hospital Expense	Paid under Hospital Expense

	Preferred Providers	Out-of-Network Providers
INPATIENT		
Surgeon's Fees , in accordance with data provided by Ingenix. If two or more procedures are performed through the same incision 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 PA	80% of U&C
Anesthetist , professional services administered in connection with inpatient surgery.	100% of PA	25% of Surgery Allowance
Registered Nurse's Services , private duty nursing care	100% of PA	80% of U&C
Physician's Visits , benefits are limited to one visit per day and do not apply when related to surgery.	100% of PA	80% of U&C
Pre-Admission Testing , payable within 3 working days prior to admission.	Paid under Hospital Expense	Paid under Hospital Expense
Psychotherapy , 30 days maximum Per Policy Year. Benefits are limited to one visit per day.	50% of PA	50% of U&C
Serious Mental Illness	See Benefits for Serious Mental Illness	See Benefits for Serious Mental Illness
OUTPATIENT		
Surgeon's Fees , in accordance with data provided by Ingenix. If two or more procedures are performed through the same incision 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 PA	80% of U&C
Day Surgery Miscellaneous , related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including the 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 PA	80% of U&C
Anesthetist , professional services administered in connection with outpatient surgery.	100% of PA	25% of Surgery Allowance
Physician's Visits , benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy. Physician's Visits will be covered at the UHS when an allergy diagnosis is made. Childhood Preventative visits included.	100% of PA	80% of U&C

	Preferred Providers	Out-of-Network Providers
OUTPATIENT		
Physiotherapy , benefits are limited to one visit per day. Medical Necessity may be reviewed during the course of treatment.	100% of PA	80% of U&C
Medical Emergency Expenses , use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	100% of PA	100% of U&C
Diagnostic X-ray and Laboratory Services	100% of PA	80% of U&C
Injections , when administered in the Physician's office and charged on the Physician's statement.	100% of PA	80% of U&C
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-Rays and Lab Procedures.	100% of PA	80% of U&C
Chemotherapy & Radiation Therapy	100% of PA	80% of U&C
Prescription Drugs , \$200 maximum for each Injury or Sickness. Birth Control (including Depo-Provera), Psychotherapy prescriptions and allergy prescriptions are covered under this benefit up to the \$200 maximum for each Injury or Sickness. Allergy prescriptions are covered at the UHS only; serums and injections are not covered under the Prescription benefit. Self-injectibles are covered under this benefit. Generic drugs must be used when available; name brand drugs will not be covered if generic is available.	100% of U&C	100% of U&C
Psychotherapy , \$30 per day maximum / \$1,200 maximum Per Policy Year. Benefits are limited to one visit per day. Including all related or ancillary charges incurred as a result of Mental & Nervous Disorder (except Prescription Drugs).	50% of PA	50% of U&C
Serious Mental Illness	See Benefits for Serious Mental Illness	See Benefits for Serious Mental Illness
OTHER		
Ambulance Services , Ground transportation \$400 maximum. Air ambulance \$2,000 maximum	100% of U&C	100% of U&C
Durable Medical Equipment	No Benefits	No Benefits
Consultant Physician Fees , when requested and approved by the attending Physician.	100% of PA	80% of U&C
Dental Treatment , \$500 per tooth. Benefits paid on Injury to Sound, Natural Teeth and the extraction of wisdom teeth only. The UHS Referral does not apply to the extraction of wisdom teeth.	100% of U&C	100% of U&C

	Preferred Providers	Out-of-Network Providers
OTHER		
Maternity and Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion, \$150 maximum	100% of PA	80% of U&C
Alcoholism / Drug Abuse	See Benefits for Alcohol / Drug Abuse and Dependency Treatment	See Benefits for Alcohol / Drug Abuse and Dependency Treatment
Repatriation/Medical Evacuation	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.

PREFERRED PROVIDER INFORMATION

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

Mt. Nittany Medical Center, Hershey Medical Center and Physicians, and Hospitals and Physicians of Devon Health (www.DevonHealth.com) Network in Pennsylvania & Beech Street (www.BeechStreet.com) outside of Pennsylvania. The Geisinger Health System, including all physicians and facilities, is no longer a Preferred Provider under the Penn State student health insurance plans. Services provided by Geisinger Health System will be paid as out of network.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-224-4810 and/or by asking the provider when making an appointment for services.

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

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

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

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

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified on the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call (888) 224-4810 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by Mt. Nittany Medical Center, Hershey Medical Center and Physicians, and Hospitals and Physicians of Devon Health Network and Beech Street will be paid at the coinsurance percentages specified on the Schedule of Benefits or up to any limits specified in the Schedule of Benefits.

OPTIONAL MAJOR MEDICAL BENEFIT

\$200,000 MAXIMUM BENEFIT (FOR EACH INJURY OR SICKNESS)

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

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

The Company will pay 100% for additional Covered Medical Expenses incurred up to the Major Medical Maximum Benefit of \$200,000. The total benefit payable under Major Medical is \$250,000 minus the Basic Benefits already paid.

No benefits will be paid under Major Medical for: 1) Hospital Expenses which exceed \$1,800 aggregate maximum per day, except at Mt. Nittany Medical Center or Hershey Medical Center which will be paid in full; 2) Intensive Care / Hospital Expenses which exceed \$2,100 aggregate maximum per day, except at Mt Nittany Medical Center or Hershey Medical Center which will be paid in full; 3) Dental treatment; 4) Psychotherapy in excess of the minimum mandated benefit specified in the Benefits for Serious Mental Illness; 5) Alcohol/Drug Abuse in excess of the minimum mandated benefit specified in Benefits for Alcohol/Drug Abuse and Dependency Treatment; and 6) Outpatient Physiotherapy.

MATERNITY TESTING

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered, if all other policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/AFP Screening and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-888-224-4810.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes solely result in any one of the following specific losses, the Company will pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of:

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

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

COORDINATION OF BENEFITS

Definitions

- (1) Allowable Expenses: Any necessary, reasonable, and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person.

An Allowable Expense to a Secondary Plan includes the value or amount of any Deductible Amount or Coinsurance Percentage or amount of otherwise Allowable Expenses which was not paid by the Primary or first paying Plan.

- (2) Plan: A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services. Such group coverages include: (a) group or blanket insurance coverage, or any other group type contract or provision thereof; this will not include school accident coverage or group hospital indemnity plan of \$100 per day or less; (b) service plan contracts, group practice and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) coverage under governmental programs, including Medicare, and any coverage required or provided by statute; this will not include a state plan under Medicaid, and will not include a law or plan when, by law, its benefits are excess to those of a private insurance plan or other non-governmental plan.
- (3) Primary: The Plan which pays regular benefits.
- (4) Secondary: The Plan which pays a reduced amount of benefits which, when added to the Primary Plan's benefits will not be more than the Allowable Expenses.
- (5) We, Us or Our: The Company named in the policy.

Effect on Benefits - If an Insured Person has medical and/or drug coverage under any other Plan, all of the benefits provided are subject to coordination of benefits.

During any policy year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Plan may not be more than the Allowable Expenses.

During any policy year or benefit period, We may reduce the amount We will pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made.

However, if: (1) the other Plan contains a section which provides for determining its benefits after Our benefits have been determined; and (2) the order of benefit determination stated herein would require Us to determine benefits before the other Plan, then the benefits of such other Plan will be ignored in determining the benefits We will pay.

This Plan determines its order of benefits using the first of the following rules which applies:

- (1) If your other Plan does not have Coordination of Benefits, that Plan pays first.
- (2) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.

- (3) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (B)(3) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
- a. the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in a. above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- (4) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
- a. first, the Plan of the parent with custody of the child;
 - b. then, the Plan of the spouse or Domestic Partner of the parent with the custody of the child; and
 - c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of these terms, the benefits of that Plan are determined first.

- (5) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Right to Recovery and Release of Necessary Information - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery - Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

This Coordination of Benefits Provision will not be applied to the first \$100 of medical expenses incurred.

If the policy contains a Deductible provision, the Deductible provision will not be applied to the first \$100 of medical expenses incurred.

MANDATED BENEFITS

BENEFITS FOR SERIOUS MENTAL ILLNESS

Benefits will be paid the same as any other Sickness for treatment of Serious Mental Illness limited to 30 inpatient days annually and 60 days outpatient annually. The Insured Person may convert Inpatient days to outpatient days on a one-to-two basis.

"Serious Mental Illness" means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the diagnostic and Statistical Manual:

- a) schizophrenia;
- b) bipolar disorder;
- c) obsessive-compulsive disorder;
- d) major depressive disorder;
- e) panic disorder;
- f) anorexia nervosa;
- g) bulimia nervosa;
- h) schizo-affective disorder;
- i) delusional disorder

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

BENEFITS FOR ALCOHOL/DRUG ABUSE AND DEPENDENCY TREATMENT

Benefits will be provided for treatment of Alcohol or Drug Abuse and dependency on the same basis as any other Sickness subject to the following:

Inpatient detoxification will be provided in a Hospital or in an inpatient non-hospital facility which has a written affiliation agreement with a Hospital for emergency, medical and psychiatric or psychological support services, meets minimum standards for client-to-staff ratios and staff qualifications that are established by the Department of Health and is licensed as an alcoholism and/or drug addiction treatment program. Inpatient detoxification is limited to no more than four (4) admissions per lifetime. Benefits are limited to seven (7) days of treatment per admission. The following services are covered under inpatient detoxification:

1. Lodging and dietary services.
2. Physician, psychologist, nurse, certified addictions counselor and trained staff services.
3. Diagnostic X-ray.
4. Psychiatric, psychological and medical laboratory testing.
5. Drugs, medicines, equipment use and supplies.

Non-Hospital residential care will be provided for thirty (30) days per policy year in a facility that meets minimum standards for client-to-staff ratios and staff qualifications that are established by the Office of Drug and Alcohol programs and is appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Insureds must be referred to the program by a Physician. Benefits are subject to lifetime maximum of ninety (90) days per person. The following services are covered under residential care:

1. Lodging and dietary service.
2. Physician, psychologist, nurse, certified addictions counselor and trained staff services.
3. Rehabilitation therapy and counseling.

4. Family counseling and intervention.
5. Psychiatric, psychological and medical laboratory tests.
6. Drugs, medicines, equipment use and supplies.

Outpatient care shall be provided in a facility appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Before an Insured may qualify to receive benefits under this section, a licensed Physician or licensed psychologist must certify the Insured as a person suffering from alcohol or other drug abuse or dependency and refer the Insured for the appropriate treatment. The following services shall be provided:

1. Physician, psychologist, nurse, certified addictions counselor and trained staff services.
2. Rehabilitation therapy and counseling.
3. Family counseling and intervention.
4. Psychiatric, psychological and medical laboratory tests.
5. Drugs, medicines, equipment use and supplies.

Treatment shall be provided for a minimum of thirty (30) outpatient, full-session visits or equivalent partial visits per policy year. These visits may not be exchanged for non-hospital, residential alcohol treatment services.

In addition, treatment shall be provided for a minimum of thirty (30) outpatient, full-session visits or equivalent partial hospitalization services per policy year. These visits may be exchanged on a two-for-one basis up to fifteen (15) non-hospital, residential alcohol treatment days.

Benefits are limited to one hundred and twenty (120) outpatient, full session visits or equivalent partial visits.

Definitions:

"Alcohol or Drug Abuse" means any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

"Detoxification" means the process whereby an alcohol-intoxicated or drug-intoxicated person is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

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

BENEFITS FOR WOMEN'S PREVENTIVE HEALTH SERVICES

Benefits will be paid the same as any other Sickness for: 1) an annual gynecological examination, including a pelvic examination and clinical breast examination; and 2) routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

The policy Deductible and dollar limitations will not be applied to this benefit. Benefits shall be subject to copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR MAMMOGRAPHIC EXAMINATION

Benefits will be paid the same as any other Sickness for mammographic examinations as follows: 1) every year for an Insured 40 years of age or older; and 2) any mammogram based on a Physician's recommendation for an Insured under 40 years of age.

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

BENEFITS FOR MANAGEMENT AND TREATMENT OF DIABETES

Benefits will be paid the same as any other Sickness for the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using if prescribed by a Physician legally authorized to prescribe such items under law.

Benefits shall be provided for equipment and supplies including the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.

Diabetes outpatient self-management training and education shall be provided under the supervision of a licensed Physician with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician shall include:

- (1) visits medically necessary upon the diagnosis of diabetes;
- (2) visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and
- (3) where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as medically necessary by a licensed Physician.

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

BENEFITS FOR POST PARTUM HOME HEALTH CARE

Benefits will be paid the same as any other Sickness for at least one home health care visit within 48 hours after discharge from inpatient care when discharge occurs prior to the time of 48 hours of inpatient care following a normal vaginal delivery and 96 hours of inpatient care following a cesarean delivery. Such visits shall be made by a Physician whose scope of practice includes post partum care. Home health care visits shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the provider.

The policy Deductible, copayment, coinsurance will not be applied to this benefit. Benefits shall be subject to all other limitations or any other provisions of the policy.

BENEFITS FOR NEWBORN INFANTS

Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to us; and 2) pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

BENEFITS FOR MASTECTOMY

Benefits will be paid the same as any other Sickness for inpatient care following a Mastectomy for the length of stay that the treating Physician determines is necessary to meet generally accepted criteria for safe discharge.

Benefits will be paid the same as any other Sickness for a home health care visit that the treating Physician determines is necessary within forty-eight (48) hours after discharge when the discharge occurs within forty-eight (48) hours following admission for the Mastectomy.

Benefits will be paid the same as any other Sickness for Prosthetic Devices, physical complications including lymphedemas, and Reconstructive Surgery incident to any Mastectomy in a manner determined in consultation with the attending Physician and the Insured Person.

Mastectomy means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed Physician. Prosthetic devices means the use of initial and subsequent artificial devices to replace the removed breast or portions thereof, pursuant to an order of the Insured's Physician.

Reconstructive surgery means a surgical procedure performed on one breast or both breasts following a Mastectomy, as determined by the treating Physician, to reestablish symmetry between the two breasts or alleviate functional impairment caused by the Mastectomy. Reconstructive surgery shall include, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy. Symmetry between breasts means approximate equality in size and shape of the nondiseased breast with the diseased breast after definitive reconstructive surgery on the diseased or nondiseased breast has been performed.

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

BENEFITS FOR CHILDHOOD IMMUNIZATIONS

Benefits will be paid the same as any other Sickness for the Named Insured who is under 21 years of age, or the Named Insured's spouse or Domestic Partner who is under 21 years of age, or a Dependent Child for those childhood immunizations, including the immunizing agents, which as determined by the Department of Health conform with the standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control) U.S. Department of Health and Human Services. The benefit will provide coverage for the cost of the immunization of a child, up to 150% of the average wholesale price (AWP), which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, the United States Department of Health and Human Services.

The policy Deductible and dollar limitations will not be applied to this benefit. Benefits shall be subject to copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR MEDICAL FOODS

Benefits will be paid the same as any other Sickness for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of Phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria that are aminoacidopathies, rare hereditary genetic metabolic disorders, and administered under the direction of a Physician. Benefits are not for normal food products used in dietary management of these disorders, but are for formulas that are equivalent to a prescription drug, medically necessary for the therapeutic treatment of such rare hereditary genetic metabolic disorders and administered under the direction of a Physician.

Benefits shall be subject to all copayment, coinsurance, limitations, or any other provisions of the policy. The policy Deductible will not be applied to this benefit.

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for a medically recognized screening examination for the detection of colorectal cancer for an Insured age 50 years of age or older and at normal risk for developing colon cancer. Benefits shall include, but not be limited to:

- a) a fecal occult blood test performed annually;
- b) a flexible sigmoidoscopy and a screening barium enema every five years; and
- c) a colonoscopy performed every 10 years;

Benefits for an Insured at high risk for colorectal cancer shall include but not be limited to: colorectal cancer screening examinations and laboratory tests as recommended by the treating Physician.

Benefits for a nonsymptomatic Insured who is at a high or increased risk for colorectal cancer and who is under fifty years of age shall include but not be limited to: a colonoscopy, sigmoidoscopy, or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008.

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

BENEFITS FOR AUTISM SPECTRUM DISORDER

Benefits will be paid the same as any other Sickness for assessment and treatment of Autism Spectrum Disorder for Insured Persons under the age twenty-one not to exceed a maximum benefit of \$36,000 per policy year. However, benefits are not subject to a maximum number of visits to an autism services provider.

“Autism Spectrum Disorders” means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger’s disorder and pervasive developmental disorder not otherwise specified.

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

DEFINITIONS

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

DEPENDENT means the spouse (husband or wife) or Domestic Partner of the Named Insured and their dependent, unmarried children. Children shall cease to be dependent on the first to occur of:

- 1) The end of the month in which they marry; or,
- 2) The end of the month in which they attain the age of nineteen (19) years; or 23 years, if a full-time dependent student at an accredited institution of higher learning.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

- 1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and,
- 2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

INJURY means bodily injury: 1) causing loss directly or independently of all other causes 2) treated by a Physician within 30 days after the date of accident; and 3) which is sustained on or after the Effective Date of insurance as to the Insured Person during the term of the policy. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in:

- 1) Death;
- 2) Placement of the Insured's health in jeopardy;
- 3) Serious impairment of bodily functions;
- 4) Serious dysfunction of any body organ or part; or
- 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICAL NECESSITY means those services or supplies provided or prescribed by a Hospital or Physician which are:

- 1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
- 2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury;
- 3) In accordance with the standards of good medical practice;
- 4) Not primarily for the convenience of the Insured, or the Insured's Physician; and,
- 5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition not separated by more than six months will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Acne; acupuncture; allergy, including allergy testing; except as specifically provided in the policy;
2. Addiction, such as: nicotine addiction;
3. Assistant Surgeon Fees;
4. Learning disabilities;
5. Biofeedback;
6. Durable Medical Equipment;
7. Circumcision;
8. Congenital conditions for cosmetic purposes only, except as specifically provided for Newborn or adopted Infants;
9. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions, except as specifically provided in the policy;
10. Dental treatment, except as specifically provided in the Schedule of Benefits;
11. Elective Surgery or Elective Treatment as defined in the policy; except cosmetic surgery necessitated by a covered Injury;
12. Eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, except where treatment is a Medical Necessity due to a covered Injury; except when due to a disease process;
13. Foot care including: care of corns, bunions (except capsular or bone surgery), calluses;
14. Hearing examinations or hearing aids; or other treatment for hearing defects and problems; except where treatment is a Medical Necessity due to a covered Injury. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
15. Hirsutism; Alopecia;
16. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
17. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
18. Injury sustained while (a) participating in any interscholastic, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
19. No benefits under the policy will duplicate any benefits provided by the Pennsylvania Motor Vehicle Financial Responsibility Law;
20. Experimental organ transplants, including organ donation;

21. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
22. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy;
 - a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
 - b) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - d) Products used for cosmetic purposes;
 - e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
 - f) Anorectics - drugs used for the purpose of weight control;
 - g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
 - h) Growth hormones; or
 - i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. Reproductive/infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
24. 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;
25. 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;
26. Services provided normally without charge by the Health Service of the Policyholder;
27. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery;
28. Skydiving, recreational parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
29. Sleep disorders;
30. Supplies, except as specifically provided in the policy;
31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

33. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
34. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

SCHOLASTIC EMERGENCY SERVICES, INC. GLOBAL EMERGENCY MEDICAL ASSISTANCE

If you are a student insured with this insurance plan, you and your insured spouse or Domestic Partner and minor child(ren) are eligible for SES services. The requirements to receive these services are as follows:

International Students, insured spouse or Domestic Partner and insured minor child(ren): You are eligible to receive SES services worldwide, except in your home country.

Domestic Students, insured spouse or Domestic Partner and insured minor child(ren): You are eligible for SES services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

SES services include Emergency Medical Evacuation and Return of Mortal Remains that meet the United States Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, any services not arranged by SES will not be considered for payment.

Key Services include:

- Medical Consultation, Evaluation and Referrals
- Foreign Hospital Admission Guarantee
- Emergency Medical Evacuation
- Critical Care Monitoring
- Medically Supervised Repatriation
- Prescription Assistance
- Transportation to Join Patient
- Care for Minor Children Left Unattended Due to a Medical Incident
- Return of Mortal Remains
- Emergency Counseling Services
- Lost Luggage or Document Assistance
- Interpreter and Legal Referrals

Please log into your online account www.uhcsr.com for additional information on SES Global Emergency Assistance Services, including service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States

(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

When calling SES's Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached.

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure for Program Guidelines as well as limitations and exclusions pertaining to the SES program.

ONLINE ACCESS TO ACCOUNT INFORMATION

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

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

CLAIM PROCEDURE

In the event of Injury or Sickness, students should:

- 1) Report to the Fishburn Clinic or University Health Services for treatment or referral, or when not in school, to their Physician or Hospital.
- 2) Mail to the address noted on the next page all medical and hospital bills along with the patient's name and insured student's name, address, PSU ID#, SR ID # (SS# for Dependents) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
- 3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare **StudentResources**

Attn: Penn State University

P.O. Box 809025

Dallas, Texas 75380-9025

1-469-229-6700 if calling from abroad

or **1-888-224-4810**

(This number is for access by Penn State University students only)

customerservice@uhcsr.com

claims@uhcsr.com

Email (Inquiries Only):

info@uhcsr.com

Penn State Student Health Insurance

302 Student Health Center

University Park, PA 16802

Telephone: 1-814-865-7467

FAX: 1-814-863-1390

studentinsurance@sa.psu.edu

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

This Certificate is based on Policy form number COL-06-PA (Rev 07-08)

School Policy 2009-547-2