UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

BENEFITS FOR TREATMENT OF MORBID OBESITY

If elected by the Policyholder, benefits will be paid as any other Sickness for all medically appropriate and necessary treatment, including surgery used to treat Morbid Obesity by Health Care Providers. The diagnosis of Morbid Obesity must be a clinical decision made by a Physician based on the appropriate medical guidelines. The Insured's Physician must certify that such services are Medically Necessary.

Treatment must be in accordance with guidelines developed by the National Institute of Health, the American Society for Bariatric Surgery, the American Medical Association and the American College of Surgeons.

"Morbid Obesity" means a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Life Insurance Tables. Morbid Obesity also means a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.

"Health Care Providers" means those Physicians and medical institutions that are specifically qualified to treat in a comprehensive manner the entire complex of illness and disease association with Morbid Obesity.

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

President

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

BENEFITS FOR HUMAN HEART TRANSPLANT

If elected by the Policyholder, benefits are payable for the treatment of Human Heart Transplant subject to all terms and conditions of the policy and the provisions of this endorsement.

With respect to the Major Medical Expense coverage, benefits will be provided for Human Heart Transplants, including any charge for acquisition, transportation, or donation of a Human Heart when a Human Heart Transplant is performed. Benefits will be provided on the same basis as for any other Sickness.

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

President

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

BENEFITS FOR MENTAL AND NERVOUS DISORDER

If elected by the Policyholder, benefits will be paid the same as any other Sickness for the treatment of Mental and Nervous Disorder subject to all terms and conditions of the policy and the provisions of this endorsement.

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

President

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

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PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the Named Insured actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured (as defined) shall be determined in accordance with the following:

1) If a Named Insured has Dependents on the date he or she is eligible for insurance; or
2) If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:

   (a) On the date the Named Insured marries the Dependent; or
   (b) On the date the Named Insured acquires a dependent child who is within the limits of a dependent, unmarried child set forth in the "Definitions" section of this policy.

Dependent eligibility expires concurrently with that of the Named Insured.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Dependent coverage will not be effective prior to that of the Named Insured.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid;
2) The date the policy terminates; or
3) The date the Named Insured's coverage terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces. Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment. The Named Insured may purchase optional coverages for himself or for himself and all Dependent family members.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

Upon receipt of due written proof of loss, the Company will have 15 working days within which to mail the Insured a letter or notice which states the reasons the Company may have for failing to pay the claim, either in whole or in part, and which also gives the Insured a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, the Company will then have 15 working days within which to process and either pay the claim or deny it, in whole or part, giving the Insured the reasons for denying such claim or any portion thereof.

For failure to comply with the requirements of this provision, the Company will pay interest to the Insured equal to 18% per annum on the proceeds or benefits due under the terms of this policy.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

RIGHT OF RECOVERY FROM THIRD PARTIES: If an Insured has a claim for damages or a right to recover damages from a third party or parties for any Sickness or Injury for which benefits are payable under this policy, the Company may have a right of recovery. The right of recovery shall be limited to the recovery of any benefits paid for identical Covered Medical Expenses under this policy, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. The Company's right of recovery may include compromise settlements. The Insured or their attorney must inform the Company of any legal action or settlement agreement at least ten days prior to settlement or trial. The Company will then notify the Insured of the amount it seeks to recover for Covered Medical Expenses paid. The Company's recovery may be reduced by the pro-rata share of the Insured's attorney's fees and expenses of litigation.

RIGHT OF RECOVERY FROM OVERPAYMENTS: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

PART III
DEFINITIONS

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy. The term "complication of pregnancy" includes non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; hyperemesis gravidarum; and, pre-eclampsia.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

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 26 years, if a full-time dependent student at an accredited institution of higher learning. For purposes of this definition, full-time dependent student includes dependents who in each calendar year after reaching the limiting age have been enrolled for five months or more as a full-time student at a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to Sickness or Injury.

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 meets all criteria on a Declaration of Domestic Partnership Form provided by the Company. The Named Insured and the Named Insured's domestic partner must submit an accurate and completed Declaration of Domestic Partnership Form, and meet all the criteria listed on the form.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing services; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental and Nervous Disorder.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

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.

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.

MENTAL AND NERVOUS DISORDER means a Sickness that is a mental, emotional or behavioral disorder. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the (International Classification of Diseases) are considered one Sickness.

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture; pathology; or disease.

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. A newly born child of the Insured shall include an adopted child. The coverage for the adopted child shall be effective from the date of the placement for adoption or final decree of adoption, whichever occurs first. 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, if any, 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.

NURSE means Registered Nurse (R.N.) who is not a member of the Insured Person's immediate family; or, when a Registered Nurse is not available and upon the recommendation of the attending Physician, a Licensed Practical Nurse (L.P.N.) who is not a member of the Insured Person's immediate family.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.
The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POSITIVE X-RAY means an X-ray that shows the presence of a fracture; pathology; or disease.

PRE-EXISTING CONDITION means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under the policy.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

PSYCHOTHERAPY means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

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.

PART IV
EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this 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 90 days after the Termination Date.

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

PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
UNIVERSITY SYSTEM OF GEORGIA – DOMESTIC - STUDENT PLAN
2012-200289-1
INJURY AND SICKNESS BENEFITS

Maximum Benefit	**$100,000 (Per Insured Person) (Per Policy Year)**
Deductible Preferred Providers	**$300 (Per Insured Person) (Per Policy Year)**
Deductible Preferred Providers	**$750 (Per Family) (Per Policy Year)**
Deductible Out of Network	**$500 (Per Insured Person) (Per Policy Year)**
Deductible Out of Network	**$900 (Per Family) (Per Policy Year)**
(The Deductible will be waived when treatment is rendered at the University Health Center. Balance billing will not apply towards satisfying the Policy Deductible.)	
Coinsurance Preferred Providers	**80% except as noted below**
Coinsurance Out of Network	**60% except as noted below**

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a 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.

PREFERRED PROVIDER SERVICES: After the Preferred Provider Deductible has been satisfied, Covered Medical Expenses incurred at a Preferred Provider will be paid at 80% of Preferred Allowance up to an Out-of-Pocket maximum of $4,500 Per Insured Person/$15,000 Per Family. After the Out-of-Pocket maximum has been reached, additional Covered Medical Expenses will be paid at 100% of Preferred Allowance up to the $100,000 Maximum Benefit.

OUT-OF-NETWORK SERVICES: After the Out-of-Network Deductible has been satisfied, Covered Medical Expenses incurred at an Out-of-Network Provider will be paid at 60% of Usual and Customary Charges up to an Out-of-Pocket maximum of $7,500 Per Insured Person/$24,000 Per Family. After the Out-of-Pocket maximum has been reached, additional Covered Medical Expenses will be paid at 100% of Usual and Customary Charges up to the $100,000 Maximum Benefit. Note: Balance billing will not apply toward the annual Deductible or toward the maximum annual out-of-pocket.

All benefit maximums are combined Preferred Provider and Out-of-Network, unless noted below. The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

UnitedHealthcare Pharmaceutical Solutions is the vendor the company contracts with to provide a network of pharmacies.

Inpatient	**Preferred Provider**	**Out-of-Network Provider**
Room & Board/Hospital	Preferred Allowance	Usual and Customary Charges
Miscellaneous:		
Intensive Care:	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care:	Paid as any other Sickness	Paid as any other Sickness
(4 days Hospital Confinement expense maximum)		
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
Surgery:	Preferred Allowance	Usual and Customary Charges
(Specified Surgery based on data provided by FAIR Health, Inc.)		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Nurse's Services:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing:	Preferred Allowance	Usual and Customary Charges
Psychotherapy:	Paid as any other Sickness	Paid as any other Sickness

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
UNIVERSITY SYSTEM OF GEORGIA – DOMESTIC - STUDENT PLAN
2012-200289-1
INJURY AND SICKNESS BENEFITS

Outpatient	**Preferred Provider**	**Out-of-Network Provider**
Surgery:	Preferred Allowance	Usual and Customary Charges
(Specified Surgery based on data provided by FAIR Health, Inc.)		
Day Surgery Miscellaneous:	Preferred Allowance	Usual and Customary Charges
(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	100% of Preferred Allowance $20 copay per visit	Usual and Customary Charges *(No preventive coverage)*
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
(30 visits maximum Per Policy Year)		
Medical Emergency:	Preferred Allowance	80% of Usual and Customary Charges
X-rays & Laboratory:	Preferred Allowance	Usual and Customary Charges
Radiation Therapy & Chemotherapy:	Preferred Allowance	Usual and Customary Charges
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges
***Prescription Drugs:**	UnitedHealthcare Network Pharmacy (UHPS) $15 copay per prescription for Tier 1 $30 copay per prescription for Tier 2 $50 copay per prescription for Tier 3 up to a 31-day supply per prescription *(University Health Center Pharmacy: Copay waived for generic drugs / $5 copay per prescription for brand name, $10 copay per prescription for non-formulary drugs / up to a 31 day supply per prescription if prescription is filled at the University Health Center Pharmacy.)*	$15 Deductible per prescription for generic drugs $30 Deductible per prescription for brand name up to a 31-day supply per prescription
*(*Mail order Prescription Drugs through UHPS at 2.5 times the retail copay up to a 90 day supply subject to the Prescription Drug maximum benefit.)*		
Psychotherapy:	Paid as any other Sickness	Paid as any other Sickness

Other	**Preferred Provider**	**Out-of-Network Provider**
Ambulance:	70% of Preferred Allowance *(If ambulance referral is initiated by Student Health Center, Deductible is waived. Subject to balance billing for non-participating/non-covered providers of ambulance services.)*	70% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
Consultant:	Preferred Allowance	Usual and Customary Charges
Dental:	Preferred Allowance	Usual and Customary Charges
(Injury to Sound, Natural Teeth and removal of full bony impacted wisdom teeth.)		

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
UNIVERSITY SYSTEM OF GEORGIA – DOMESTIC - STUDENT PLAN
2012-200289-1
INJURY AND SICKNESS BENEFITS

Other	Preferred Provider	Out-of-Network Provider
Alcoholism/Drug Abuse:	Paid under Psychotherapy $20 copay per visit	Paid under Psychotherapy
(Benefits for treatment of alcoholism and drug abuse include services received from licensed alcohol and drug treatment facilities.)		
Maternity:	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion:	No Benefits	No Benefits
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Repatriation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
Medical Evacuation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
AD&D:	No Benefits	No Benefits
***Intercollegiate Sports:**	No Benefits	No Benefits
($10,000 maximum) (Optional: Additional Premium Required)		
TMJ Disorder:	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services:	100% of Preferred Allowance	100% of Usual and Customary Charges
(No Deductible, copay or coinsurance will be applied to Preventive Care Services when treatment is received by a Preferred Provider. Preventive Care Services are limited to the following recommended preventive services: 1) U.S. Preventive Services Task Force (USPSTF) recommendations of "A" or "B"; 2) immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the CDC; 3) with respect to Insureds who are infants, children and adolescents, evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and 4) with respect to Insureds who are women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the HSRA.)		
Needle Stick/Blood & Body Fluid and Infectious Disease Exposure:	Preferred Allowance	No Benefits

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
UNIVERSITY SYSTEM OF GEORGIA – DOMESTIC - STUDENT PLAN
2012-200289-1
INJURY AND SICKNESS BENEFITS

MAJOR MEDICAL

Maximum Benefit **No Benefits**

CATASTROPHIC MEDICAL

Maximum Benefit **No Benefits**

***SHC Referral Required: Yes (X) No ( ) Conversion Permitted: Yes ( ) No (X)**

( ) 52 Week Benefit Period or (X) Extension of Benefits

***Pre Admission Notification: Yes (X) No ( )**

Other Insurance: (X) *Coordination of Benefits ( ) Excess Motor Vehicle ( ) Primary Insurance

*If benefit is designated, see endorsement attached.

PREFERRED PROVIDER INFORMATION

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

UnitedHealthcare Choice Plus.

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

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

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

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

Inpatient Hospital Expenses

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

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Choice Plus will be paid at the coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

PART VI
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.

2. **Intensive Care:** If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies 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.

4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. The benefits and the maximum amounts are specified in the Schedule of Benefits.

5. **Physiotherapy (Inpatient):** See Schedule of Benefits.

6. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.

7. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.

8. **Anesthetist Services:** professional services administered in connection with inpatient surgery.

9. **Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

10. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.

11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.

12. **Psychotherapy (Inpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits. Benefits are limited to one visit per day.

13. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.

14. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.

15. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

16. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

17. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.

18. **Physiotherapy (Outpatient):** benefits are limited to one visit per day.

19. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.

20. **Diagnostic X-ray Services (Outpatient):** Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.

21. **Radiation Therapy (Outpatient):** See Schedule of Benefits.

22. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.

23. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.

24. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.

25. **Chemotherapy (Outpatient):** See Schedule of Benefits.

26. **Prescription Drugs (Outpatient):** See Schedule of Benefits.

27. **Psychotherapy (Outpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits. Benefits are limited to one visit per day.

28. **Ambulance Services:** See Schedule of Benefits.

29. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.

30. **Consultant Physician Fees:** when requested and approved by the attending Physician.

31. **Dental Treatment:** performed by a Physician. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

32. **Alcoholism/Drug Abuse Treatment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

33. **Maternity:** Same as any other Sickness.

34. **Complications of Pregnancy:** Same as any other Sickness.

35. **Repatriation:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Supplemental Medical coverage.

36. **Medical Evacuation:** 1) when Hospital Confined for at least five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Supplemental Medical coverage.

37. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

38. **Intercollegiate Sports:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

PART VII
MANDATED BENEFITS

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Sickness for a mammogram subject to all of the terms and conditions of the policy and according to the following guidelines:

1. Once as a baseline mammogram for any female who is at least 35 but less than 40 years of age;
2. Once every two years for any female who is at least 40 but less than 50 years of age;
3. Once every year for any female who is at least 50 years of age; and
4. When ordered by a Physician for a female at risk. For purpose of this benefit, **"Female at risk"** means a woman:

    a. Who has a personal history of breast cancer;
    b. Who has a personal history of biopsy proven benign breast disease;
    c. Whose grandmother, mother, sister, or daughter has had breast cancer; or
    d. Who has not given birth prior to the age of 30.

Reimbursement will be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by the state of Georgia.

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

BENEFITS FOR PAP SMEARS

Benefits will be paid the same as any other Sickness for an annual "Pap smear" or "Papanicolaou smear" examination for the purpose of detecting cancer, or more frequently if ordered by a Physician. The examination must be performed in accordance with standards established by the American College of Pathologists.

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

BENEFITS FOR PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) or equivalent tests for the presence of prostate cancer when recommended by a Physician. All tests must be performed in accordance with standards established by the American College of Pathologists.

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

BENEFITS FOR CHLAMYDIA SCREENING

Benefits will be paid the same as any other Sickness for one annual chlamydia screening test for each Insured Person. "Chlamydia screening test" means any laboratory test of the urogenital tract which specifically detects for infection by one or more agents of chlamydia trachomatis and which test is approved for such purposes by the federal Food and Drug Administration.

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

BENEFITS FOR MASTECTOMY

Benefits will be paid the same as any other Sickness for a mastectomy including the expense of breast reconstructive surgery of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedemas, and at least two external postoperative prostheses incidental to the covered mastectomy. Coverage will be provided in a manner determined in consultation with the attending physician.

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

BENEFITS FOR BONE MASS MEASUREMENT

Benefits will be paid the same as any other Sickness for Qualified Insured Persons for scientifically proven Bone Mass Measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis.

(1) "Bone mass measurement" means a radiologic or radioisotopic procedure or other technologies approved by the United States Food and Drug Administration and performed on an individual for the purpose of identifying bone mass or detecting bone loss.
(2) "Qualified Insured Person" means an:
   (A) Estrogen-deficient woman or individual at clinical risk of osteoporosis as determined directly or indirectly by a physician and who is considering treatment;
   (B) Individual with osteoporotic vertebral abnormalities;
   (C) Individual receiving long-term glucocorticoid (steroid) therapy;
   (D) Individual with primary hyperparathyroidism; or
   (E) Individual being monitored directly or indirectly by a physician to assess the response to or efficacy of approved osteoporosis drug therapies.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for colorectal cancer screening, examinations and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology and that are deemed appropriate by the attending physician.

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

BENEFITS FOR DENTAL ANESTHESIA

Benefits will be provided for general anesthesia and associated hospital and ambulatory surgical facility charges in conjunction with dental care provided to an Insured, if such person is:

1. Seven years of age or younger or is developmentally disabled;
2. An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Insured; or
3. An individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.

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

BENEFITS FOR DIABETES

Benefits will be provided for all medically appropriate and necessary equipment, supplies, pharmacologic agents, and diabetes self-management training and educational services used to treat diabetes, if the Insured's Physician certifies that such services are Medically Necessary. Diabetes self-management training, educational services and nutrition counseling must be provided under the direct supervision of a Physician.

"Diabetes self-management training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

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

BENEFITS FOR SURVEILLANCE TESTS FOR OVARIAN CANCER

Benefits will be paid the same as any other Sickness for surveillance tests for ovarian cancer for an Insured Person age 35 and older at risk for ovarian cancer.

At risk for ovarian cancer means having a family history: with one or more first or second degree relatives with ovarian cancer; of clusters of women relatives with breast cancer; of nonpolyposis colorectal cancer; or testing positive for BRCA1 or BRCA2 mutations.

Surveillance tests means annual screening using: CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.

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

BENEFITS FOR TELEMEDICINE

Benefits will be paid the same as any other Sickness for Telemedicine. "Telemedicine" means the practice, by a duly licensed Physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof do not constitute telemedicine services.

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

BENEFITS FOR DRUG TREATMENT OF CHILDREN'S CANCER

Benefits will be paid the same as any other Sickness for routine patient care costs incurred in connection with the provision of goods or services to Dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those children who are enrolled in an approved clinical trial program for treatment of children's cancer and are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors or other similar sources.

"Approved clinical trial program for treatment of children's cancer" means a Phase II and III prescription drug clinical trial program in this state, as approved by the federal Food and Drug Administration or the National Cancer Institute for the treatment of cancer that generally first manifests itself in children under the age of 19. Such program must: (i) test new therapies, regimens, or combinations thereof against standard therapies or regimens for the treatment of cancer in children; (ii) introduce a new therapy or regimen to treat recurrent cancer in children; or (iii) seek to discover new therapies or regimens for the treatment of cancer in children which are more cost effective than standard therapies or regimens. Such program must be certified by and utilize the standards for acceptable protocols established by the Pediatric Oncology Group or Children's Cancer Group.

"Routine patient care costs" means those medically necessary costs of blood tests, X-rays, bone scans, magnetic resonance images, patient visits, hospital stays, or other similar costs generally incurred by the insured party in connection with the provision of goods, services, or benefits to dependent children under an approved clinical trial program for treatment of children's cancer which otherwise would be covered under the supplemental medical accident and sickness insurance benefit plan, policy, or contract if such medically necessary costs were not incurred in connection with an approved clinical trial program for treatment of children's cancer. Routine patient care costs specifically shall not include the costs of any clinical trial therapies, regimens, or combinations thereof, any drugs or pharmaceuticals, any costs associated with the provision of any goods, services, or benefits to dependent children which generally are furnished without charge in connection with such an approved clinical trial program for treatment of children's cancer, any additional costs associated with the provision of any goods, services, or benefits which previously have been provided to the Dependent child, paid for, or reimbursed, or any other similar costs.

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

BENEFITS FOR BONE MARROW TRANSPLANTS

Benefits will be paid the same as any other Sickness for bone marrow transplants.

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

PART VIII
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. Biofeedback;

2. Congenital conditions, except as specifically provided for Newborn or adopted Infants;

3. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;

4. Dental treatment, except as specifically provided in the Schedule of Benefits;

5. Elective Surgery or Elective Treatment;

6. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;

7. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

8. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

9. Hirsutism; alopecia;

10. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;

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

12. Injury sustained while (a) participating in any 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;

13. Investigational services;

14. Organ transplants, including organ donation;

15. Participation in a riot or civil disorder; commission of or attempt to commit a felony;

16. 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, except as specifically provided in the Benefits for Drug Treatment for Children's Cancer;
    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;

17. Reproductive/Infertility services including but not limited to: family planning, except contraceptives; fertility tests; infertility (male or female), except Covered Medical Expenses relating to diagnosis, 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;

18. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

19. Deviated nasal septum, including submucous resection and/or other surgical correction thereof;

20. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

21. Sleep disorders;

22. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;

23. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

24. 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

25. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

It is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

COORDINATION OF BENEFITS PROVISION

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 for which the parent pays the entire premium; (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.

(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 to which this endorsement is attached.

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) 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.

COORDINATION OF BENEFITS PROVISION (Continued)

(2) Dependent Child/Parents Not Separated or Divorced. 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.

c. 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.

(3) 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:

1. first, the Plan of the parent with custody of the child;

2. then, the Plan of the spouse of the parent with the custody of the child; and

3. finally, the Plan of the parent not having custody of the child.

(4) 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.

President

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

It is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

PRE-ADMISSION NOTIFICATION

UMR Care Management should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

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

UMR Care Management 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.

President

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

It is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

STUDENT HEALTH CENTER (SHC) REFERRAL REQUIRED
STUDENTS ONLY

The student must use the services of the Health Center first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary only under the following conditions:

1. Medical Emergency. The student must return to SHC for necessary follow-up care;
2. When the Student Health Center is closed;
3. When service is rendered at another facility during break or vacation periods;
4. Medical care received when the student is more than 30 miles from campus;
5. Medical care obtained when a student is no longer able to use the SHC due to a change in student status;
6. Maternity or
7. Psychotherapy.

Dependents are not eligible to use the SHC; and therefore, are exempt from the above limitations and requirements.

President

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

UNITED HEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

UnitedHealthcare Network Pharmacy Prescription Drug Benefits

Benefits are available for Prescription Drug Products at a Network Pharmacy as specified in the policy Schedule of Benefits subject to all terms of the policy and the provisions, definitions and exclusions specified in this endorsement.

Copayment and/or Coinsurance Amount

For Prescription Drug Products at a retail Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable copayment and/or coinsurance; or
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable copayment and/or coinsurance; or
- The Prescription Drug Cost for that Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Schedule of Benefits. For a single copayment and/or coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the copayment and/or coinsurance that applies will reflect the number of days dispensed.

When a Prescription Drug Product is dispensed from a Mail Order Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.uhcsr.com or by calling *Customer Service* at 1-877-417-7345.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change, and therefore the copayment and/or coinsurance may change. The Insured will pay the copayment and/or coinsurance applicable for the tier to which the Prescription Drug is assigned.

Notification Requirements

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Insured's Physician, Insured's pharmacist or the Insured is required to notify the Company or our designee. The reason for notifying the Company is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Medical Expense.
- It is not an Experimental or Investigational or Unproven Service.

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.uhcsr.com or by calling *Customer Service* at 1-877-417-7345.

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured can ask the Company to consider reimbursement after the Insured receives the Prescription Drug Product. The Insured will be required to pay for the Prescription Drug Product at the pharmacy.

When the Insured submits a claim on this basis, the Insured may pay more because they did not notify the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Cost, less the required copayment and/or coinsurance and any Deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Company reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Medical Expense or it is an Experimental or Investigational or Unproven Service.

Limitation on Selection of Pharmacies

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person's selection of Network Pharmacies may be limited. If this happens, the Company may require the Insured to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the designated single Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will select a single Network Pharmacy for the Insured.

Coverage Policies and Guidelines

The Company's Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on its behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

The Company may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to the Insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. Please access www.uhcsr.com through the Internet or call *Customer Service* at 1-877-417-7345 for the most up-to-date tier status.

Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company does not pass these rebates on to the Insured Person, nor are they taken into account in determining the Insured's copayments and/or coinsurance.

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Endorsement. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

Definitions

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

Chemically Equivalent means when Prescription Drug Products contain the same active ingredient.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

1) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
2) Subject to review and approval by any institutional review board for the proposed use.
3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If the Insured has a life-threatening Injury or Sickness (one which is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

1) Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
2) Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Unproven Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

Prescription Drug Cost means the rate the Company has agreed to pay the Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call *Customer Service* at 1-877-417-7345.

Prescription Drug List Management Committee means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Therapeutically Equivalent means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Fee means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Fee includes a dispensing fee and any applicable sales tax.

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

This endorsement takes effect and expires concurrently with the policy to which it is attached and is subject to all of the terms and conditions of the policy not inconsistent therewith.