This Plan is Underwritten by
UnitedHealthcare Insurance Company
2013 - 2014
Student Injury Insurance Plan
EXCESS COVERAGE
Designed Especially for Students of

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This Certificate is subject to the Laws of the State of New Jersey

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 1-800-505-4160 or visiting us at www.firststudent.com.

Eligibility

All full-time domestic undergraduate students taking 12 credit hours or more, domestic graduate students taking 9 credits or more, all international students and students in the Foods and Nutrition, Dietetic Internship Program where minimum credit is needed to graduate or complete course study are automatically enrolled in this insurance Plan at registration, and the premium is paid by the school.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its 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.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 15, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company or its authorized representative, whichever is later. The Master Policy terminates at 11:59 p.m., August 14, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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

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

Extension of Benefits After Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury will continue to be paid as long as the condition continues but not to exceed 90 days after the termination date

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

After 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

UnitedHealthcare 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.

UnitedHealthcare 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.

Schedule of Medical Expense Benefits

Injury Only Benefits

Up to $25,000 Maximum Benefit Paid as Specified Below (For Each Injury)

Deductible: $0

Coinsurance: 100% except as noted below

The Policy provides benefits for the Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury.

Usual and Customary Charges are based on data provided by FAIR Health, Inc. using the 90th percentile based on location of provider.

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

U&C = Usual and Customary Charges

INPATIENT	
Hospital Expense, daily semi-private room rate; and 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 U&C
Physiotherapy	100% of U&C
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	100% of U&C
Assistant Surgeon	100% of U&C
Anesthetist, professional services in connection with inpatient surgery.	100% of U&C
Registered Nurse's Services, private duty nursing care.	100% of U&C
Physician's Visits, benefits do not apply when related to Surgery.	100% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	100% of U&C

OUTPATIENT	
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	100% of U&C
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous and based on the Outpatient Surgical Facility Charge Index.	100% of U&C
Assistant Surgeon	100% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	100% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of U&C
Physiotherapy	100% of U&C
Medical Emergency Expenses, use of the emergency room and supplies. Treatment must be rendered within 72 hours from the time of Injury.	100% of U&C
Diagnostic X-Ray and Laboratory Services	100% of U&C
Test & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-ray and lab procedures.	100% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	100% of U&C
Prescriptions Drugs	No Benefits
OTHER	
Ambulance Services	100% of U&C
Durable Medical Equipment	100% of U&C
Consultant Physician Fees, when requested and approved by the attending Physician.	100% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth.	100% of U&C
Home Health Care	See Benefits for Home Health Care

Excess Provision

No benefits are payable for any expense incurred for Injury which has been paid or is payable by other valid and collectible insurance.

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

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

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

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

Mandated Benefits

Benefits for Home Health Care

Benefits for Home Health Care as hereinafter defined will be paid on the same basis as any other Injury.

"**Home Health Care**" means those nursing and other home health care services rendered to an Insured who is the patient in his place of residence, under the following conditions:

1. On a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term (no more than 3 days) basis;
2. If continuing Hospitalization would otherwise have been required if home health care were not provided; and
3. Pursuant to a Physician's written order and under a plan of care established by the responsible Physician working with a Home Health Care Provider. The Physician must review the plan monthly and certify monthly that continued confinement in a Hospital would otherwise be required. That Physician may not be related to the Home Health Care Provider by ownership or contract. All care plans shall be established within 14 days following commencement of home health care.

"**Home Health Care Provider**" means a home health care agency which is certified to participate as a home health agency under Title XVIII of the Social Security Act or licensed by the New Jersey Commissioner of Health and Senior Services as a home health agency.

"**Home Health Care Services**" means any of the following services which are Medically Necessary to achieve the plan of care referred to in condition (3) above and are provided for the care of the Insured Person: nursing care (furnished by or under the supervision of a Registered Nurse); physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would be covered by this policy if the Insured were in a Hospital; and any diagnostic or therapeutic service, including surgical services performed in a Hospital outpatient department, a Physician's office or any other licensed health care facility, to the extent such service would be covered by this policy if performed as an inpatient Hospital service, provided that service is performed as part of the plan of care.

LIMITATIONS - Home Health Care Benefits are subject to the following limitations:

1. Services must follow a Hospital Confinement of at least 3 consecutive days. Services must begin not more than 3 days after the end of that confinement.
2. Any visit by a member of a home health care team on any day will be considered one home health care visit. Benefits will be provided for no more than 60 home health care visits in any period of 12 consecutive months.
3. The amount payable for a home health care visit shall not exceed for each of the first three days on which services are provided the daily room and board benefit provided by this policy during the prior confinement; for each subsequent day of such services, the amount payable shall not exceed one-half of the daily room and board benefit provided by this policy during the prior confinement.
4. The services and supplies must be furnished and charged for by a Home Health Care Provider.

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

Definitions

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) as specified in the Schedule of Benefits.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a 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 service by Registered Nurses; 5) provides organized facilities or diagnosis and major surgery on the premises or on a pre-arranged basis; 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 for which benefits are payable.

FAIR Health, Inc. is a research and consulting firm that focuses on medical coding and reimbursement issues. The Company uses data received from Ingenix to determine Usual and Customary Charges.

INJURY means bodily injury of an Insured Person: 1) caused by an accident which occurs while the policy is in force as to that Insured Person; 2) treated by a Physician within 30 days after the date of accident; and 3) which results directly and independently of all other causes in loss covered by the policy.

INSURED PERSON means the Named Insured. 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 occurance of a sudden, serious and unexpected Injury manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in:

1) Death;
2) Placement of the Insured's health in jeopardy;
3) Serious impairment of bodily functions; or
4) Serious dysfunction of any body organ or part;.

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

MEDICAL NECESSITY means or describes a health care service that a Hospital or Physician, exercising prudent clinical judgment, would provide to an Insured Person for the purpose of evaluating, diagnosing or treating an Injury or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Insured Person's Injury; not primarily for the convenience of the Insured Person or the Physician; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Insured Person's Injury.

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.

The 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.

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.

OTHER VALID AND COLLECTIBLE GROUP INSURANCE means: 1) any group plan, program or insurance policy; 2) any other group hospital, surgical or medical benefit plan; 3) union welfare plans; or 4) group employer or employee benefit programs.

PHYSICIAN means: a duly qualified licensed Physician or any provider of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws, other than a member of the Insured's immediate family:

The term "member of the immediate family" means husband, wife, children, father, mother, brother, sister, and the corresponding in-laws.

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.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

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, including "off-label" use of Food and Drug Administration ("FDA")-approved drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

Prescription Drugs also means a drug prescribed for treatment which has not been approved by the FDA, however, the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in the: 1) American Hospital Formulary Service Drug Information; 2) United States Pharmacopeia Drug Information; or is recommended by a clinical study or review article in a major peer-reviewed professional journal.

Prescription Drugs does not mean any experimental or investigational drug; or any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

SOUND NATURAL TEETH means natural teeth, the major portion of which are present, regardless of fillings.

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 where service is rendered. 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. Biofeedback;
2. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;
3. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
4. Elective Surgery or Elective Treatment;

5. 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;
6. Health spa or similar facilities; strengthening programs;
7. Preventive medicines or vaccines, except where required for treatment of a covered Injury;
8. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
9. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
10. Loss sustained or contracted as a consequence of the Insured Person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a Physician;
11. Participation in a riot or civil disorder; Loss to which a contributing cause was the Insured Person's commission of or attempt to commit a felony or to which a contributing cause was the Insured Person's engagement in an illegal occupation;
12. Prescription Drugs dispensed or purchased while not Hospital Confined;
13. Services provided normally without charge;
14. Sickness or disease in any form; or hernia, regardless of how caused;
15. 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;
16. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
17. Supplies, except as specifically provided in the policy;
18. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; or snowmobile skiing scuba diving, surfing, roller skating, riding in a rodeo; and
19. War or any act of war, declared or undeclared: 1) While the Insured Person is serving in the armed forces of any country; 2) while the Insured Person is serving in any civilian non-combatant unit supporting or accompanying any armed forces of any country or international organization; or 3) while the Insured Person is not serving in any armed forces if the Injury occurs outside the 50 states of the United States of America, the District of Columbia or Canada. A pro-rata premium will be refunded upon request for such period not covered.

Resolution of Grievances

You, the Insured, will be notified in writing by us if a claim or any part of your claim is denied. The notice will include the specific reason or reasons for the denial and the reference to the pertinent plan provision(s) on which the denial was based.

If you have a complaint about your claim denial, you may call our Customer Service telephone number 1-800-505-4160 for further explanation to informally resolve your complaint. If you are not satisfied with our explanation of why the claim was denied, you, your authorized representative or provider may request an internal review of the claim denial. The following is our grievance review process:

1) The Insured must request in writing a benefit review within 60 days after the date that you receive the notice denying your claim. This will be an informal reconsideration review process of your claim by a Claims Supervisor. The Insured may not attend this review.
2) A decision will be made by the Claims Supervisor, within 30 days after the receipt of your request for review or the date all information required from the Insured is received.
3) If the Claims Supervisor denies the claim submitted for review and you are not satisfied with the explanation for the decision, you may request a first-level grievance review. The Insured is not required to attend the first level review.

Expedited Review

An expedited review will be conducted for any claim that is denied on the basis that the service or procedure did not meet the Medical Necessity criteria set out in the Definitions section of the policy. An expedited review follows the same procedures as any other grievance review, but is accomplished in a shorter time period. These time periods are shown below under the First Level and Second Level Grievance Review sections.

First Level Grievance Review

1) The first level grievance material must be submitted to us in writing by the Insured or his/her provider for consideration by the first level reviewers who shall be our employees other than those responsible for claims payment on a day-to-day basis. The first level grievance review shall be provided at no cost to the Insured or his/her provider.
2) A first level review written decision will be issued to the Insured and, if applicable, the Insured's provider, within 10 days (5 days for Expedited Review) of the receipt of the grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a first-level grievance review shall contain:
   A) The names, titles, professional credentials, qualifications and licensure of the person or persons reviewing the grievance.
   B) A statement of the reviewer's understanding of the grievance.
   C) The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Insurer's position.
   D) A reference to the evidence or documentation used as the basis for the decision.
   E) If the decision is adverse, a statement advising the Insured or provider of his or her right to request an external adverse decision review or second-level grievance review and a description of the procedure for submitting a second-level grievance.

Second Level Grievance Review

1) A second level grievance review is available through an independent party to the Insured or provider dissatisfied with the first level grievance review decision. The costs of a second level grievance review requested by a provider will be shared by the parties.
2) Within 10 days (5 days for Expedited Review) of the receipt of the request for the second level review, we will provide the following information to the Insured:

A) The name, address and telephone number of the grievance review coordinator.

B) A statement of the Insured's rights, including the right to:

1) Request and receive from us all information relevant to the case;

2) Present his/her case to the review panel;

3) Submit supporting material prior to and at the review meeting;

4) Ask questions of any member of the panel; and

5) Be assisted or represented by a person of the Insured's choosing, including a family member, employer representative or attorney.

3) We will convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not our employees, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, if we used a clinical peer on an appeal on a first-level grievance review panel then we may use one of our employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

4) The second level grievance review meeting will be held within 45 days (15 days for an Expedited Review) of receipt of the second level review request.

5) The Insured will receive at least 15 days (5 days for an Expedited Review) notice of the second level grievance review meeting date.

6) The Insured will have the right to full review without condition of his/her attendance at the meeting.

7) A written statement of the second level grievance review panel's decision shall be issued to the Insured within 30 business days (5 business days for an Expedited Review) after the review meeting. The decisions shall include:

A) The professional qualifications and licensure of the members of the review panel.

B) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

C) The review panel's recommendation to the Insurer and the rationale behind that recommendation.

D) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.

E) In the review of a clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.

F) The rationale for the Insurer's decision if it differs from the review panel's recommendation.

G) A statement that the decision is the Insurer's final determination in the matter.

H) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

The New Jersey Department of Banking and Insurance has established the Independent Health Care Appeals Program. The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by

the Insured or any health care provider acting on behalf of the Insured but only with the Insured's consent. The appeal review shall not include any decisions regarding benefits not covered by the Insured's health benefit plan. The decisions rendered through the Independent Health Care Appeals Program (IHCAP) are binding.

An Insured or Health Care Provider may apply to the Independent Health Care Appeals Program for a review of a decision to deny, reduce or terminate a benefit if the Insured has already completed our appeals process and the Insured contests the final decision by us. The Insured shall apply to the department within 60 days of the date the final decision was issued by us, in a manner determined by the commissioner.

As part of the application, the Insured or Health Care Provider shall provide the department with:

(1) The name and business address of the carrier;

(2) A brief description of the Insured's medical condition for which benefits were denied, reduced or terminated;

(3) A copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the benefit; and

(4) A written consent to obtain any necessary medical records from the carrier and, in the case of a managed care plan, any other out-of-network physician the person may have consulted on the matter.

The Insured shall pay the department an application processing fee of $25, except that the commissioner may reduce or waive the fee in the case of financial hardship. The health care provider acting on the Insured's behalf shall bear all costs associated with the appeal that are normally paid by the Insured.

Prior to receiving hospital services, an Insured or a person designated by the Insured may sign a consent form authorizing a health care provider acting on the Insured's behalf to appeal a determination by the Company to deny, reduce or terminate benefits. The consent is valid for all stages of the Company's informal and formal appeals process and the Independent Health Care Appeals Program. An Insured shall retain the right to revoke his consent at any time.

A health care provider shall provide notice to the Insured whenever the health care provider initiates an appeal of the Company's determination to deny, reduce or terminate a benefit or deny payment for a health care service based on a medical necessity determination made by the Company. The health care provider shall provide additional notice to the Insured each time the health care provider continues the appeal to the next stage of an appeals process, including any appeal to an independent utilization review organization.

The New Jersey Department of Banking and Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the New Jersey Department of Banking and Insurance, Office of Consumer Protection Services, Division of Insurance, 20 West State Street, 9th Floor, PO Box 329, Trenton, NJ 08625-0329 or by telephone at (609) 292-5316, ext. 17902. You may also contact UnitedHealthcare **Student**Resources in writing at UnitedHealthcare **Student**Resources, Attn: Claims Appeals, PO Box 809025, Dallas, TX 75380-9025 or by telephone at (800) 505-4160.

Handling Claims

Written notice of claim must be given to the Insurer within 30 days after the date of Injury for a covered loss, or as soon as reasonably possible.

A Company claim form is not required for filing a claim. Mail to the First Student at P.O. Box 809025, Dallas, Texas 75380-9025 all medical and Hospital bills along with the patient's name and Insured student's name, address, social security number and name of the Policyholder under which the student is Insured.

Written proof of loss must be given to the Insurer at P.O. Box 809025, Dallas, Texas 75380-9025 within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible.

Indemnities payable under the policy for any loss will be paid upon receipt of due written proof of such loss. Eligible claims submitted electronically will be paid on the earlier of: a) the 30th calendar day following receipt of the claim; or b) the time limit established by Medicare pursuant to 42 U.S.C. s. 1395u(c)(2)(B). For eligible claims submitted by other than electronic means, payment will be made no later than the 40th calendar day following receipt of the claim.

The claim payment will be made on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means following receipt by the Company of the required documentation or modification of an initial submission. The Company will notify the Insured or the Insured's representative and the provider of services within 30 days of the receipt of the claim: a) if the claim is incomplete including a statement as to what substantiating documentation is required for adjudication of the claim; b) if the claim contains incorrect information (including incorrect coding), including a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; c) if the Company disputes the amount of the claim, including a statement as to the basis for the dispute; and d) when the claim is being investigated for suspected fraud or referred to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety due to strong evidence of fraud.

All overdue payments shall bear simple interest at the rate of 12% per annum.

All benefits are payable to the Insured. If the Insured is a minor, such benefits may be made payable to his or her parent, guardian or other person chiefly supporting him or her. A loss of life benefit, if any, will be paid in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, that benefit shall be paid to the estate of the Insured Person. Any other benefits unpaid at the death of the Insured Person may, at our option, be paid to the beneficiary (other than the Policyholder or an officer of the Policyholder as such) or the Insured Person's estate. Subject to any written direction of the Insured, all or a portion of any benefits payable under the policy may be paid directly to the Hospital, Physician or person rendering the service or treatment. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

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.

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of the 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.

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to ***My Account*** at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "My Account" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare **Student**Resources' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account has been enhanced to include *Message Center* - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to ***My Account*** as described above and select *UnitedHealth Allies Plan* to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

ID Cards

One way we are becoming greener is to no longer automatically mail out ***ID Cards***. Instead, we will send an email notification when the digital ID card is available to be downloaded from ***My Account***. An Insured student may also use ***My Account*** to request delivery of a permanent ID card through the mail. ID Cards may also be accessed via our mobile site at my.uhcsr.com.

The Plan is Underwritten by:
UnitedHealthcare Insurance Company

Submit all Claims or Customer Service Inquiries to:
First Student
P. O. Box 809025
Dallas, TX 75380-9025
1-800-505-4160
or visit our website at www.firststudent.com

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

This Certificate Is Based On Policy Number:
2013-1665-91