UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

("the Policyholder")

2009–2010

Student Accident and Sickness Insurance Plan

Insurance is Underwritten by
National Union Fire Insurance Company
of Pittsburgh, Pa.,
with its principal place of business in
New York, NY ("the Company")

Administrator Policy Number: AMH0079710
Underwriter Reference Number: CAS9710760

This brochure is a brief description of the coverage available under policy series S30494NUFIC. The Master Policy on file at the University contains all of the definitions, provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between this brochure and the Master Policy, the Master Policy will govern and control the payment of benefits.

Eligibility

All registered, full-time graduate students and post-doctoral candidates are eligible to enroll in this insurance plan.

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

Students who do enroll in the Plan may also enroll their Dependents. Eligible dependents are the spouse residing with the Covered Student and unmarried children under 19 years of age, or under 23 years of age if a full-time student as defined by the school he or she attends, who are not self-supporting. Dependent coverage must be purchased at the same time that the student enrolls in the plan.

Effective and Termination Dates

Coverage becomes effective on the latest of:

- The Policy effective date: August 1, 2009 at 12:01 a.m.; or
- The date for which premium for the Covered Student's coverage is paid; or
- The date the Covered Student becomes eligible for coverage.

Coverage will terminate on the earliest of:

- The last day for which premium has been paid for the Covered Person; or
- The date the Covered Person becomes ineligible for coverage; or
- The termination date of the Policy: August 1, 2010 at 12:01 a.m.

Dependent coverage will not be effective prior to that of the Covered Student or extend beyond that of the Covered Student, except as specifically provided in the Extension of Benefits provision.

Open enrollment deadline is September 1, 2009. New incoming students must submit their enrollment form by the 10th business day after the effective date of the academic term for their specific program.

Students may elect to purchase coverage after the enrollment deadline within 31 days of the following qualifying events only*:

- Within 31 days of changes in family composition due to marriage, birth or adoption of a child, or divorce.
- Loss of coverage under another creditable plan due to ineligibility.

*Proof is required at the time of enrollment

Extension of Benefits

If, on the date coverage terminates, a Covered Person is Totally Disabled as a result of Sickness or Injury and is receiving treatment for such Sickness, Injury or pregnancy, benefits will be payable for the Eligible Expenses incurred for that Sickness, Injury or pregnancy after the date coverage terminates until the earliest of the following: (1) the end of the Sickness or Injury that caused the Total Disability; (2) the date the pregnancy ends; or (3) the end of the 12 month period following the date coverage terminated. The Covered Person may be required to provide proof of Total Disability.

If the Covered Person is confined to a Hospital on the date his or her coverage terminates as a result of Sickness or Injury for which benefits were payable prior to the date his or her coverage terminated, benefits will be payable for the Eligible Expenses incurred until the earlier of: (1) the date the Covered Person is discharged from the Hospital; or (2) the end of the 12 month period following the date his or her coverage terminated.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

Certificate of Creditable Coverage

Coverage under this health plan is "creditable coverage" under Federal Law. When the Covered Person's coverage terminates, he or she can request a Certificate of Creditable Coverage, which is evidence of his or her coverage under the Policy. The Covered Person may need such a certificate if he or she becomes covered under a group health plan or other health plan within 63 days after his or her coverage under the Policy terminates. If the subsequent health plan excludes or limits coverage for medical conditions the Covered Person had before enrolling, this Certificate may be used to reduce or eliminate those exclusions or limitations. In order to obtain a Certificate of Creditable Coverage, please contact Maksin Management Corp, P.O. Box 2647, Camden, NJ 08101-2647. Or you may call toll free at 1-877-775-5430.

Definitions

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

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

"Covered Student" means a student of the Policyholder who is insured under the Policy.

"Doctor" means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing service within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term "Doctor" does not include a Covered Person's immediate family member.

"Elective Treatment" means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage.

Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; botox injections; treatment of infertility and routine physical examinations, except as specifically provided under the Policy.

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

"Emergency Medical Condition" means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) seriously impairment to such person's bodily functions; or (c) serious dysfunction of any bodily organ or part of such person.
The Covered Person is not required to obtain prior authorization before accessing the 911 system or other State, county or local government emergency medical services system for an emergency medical condition.

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

"Medical Necessity/Medically Necessary" means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.
A service or supply will not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is experimental/investigational or for research purposes; or (e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.
The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

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

"**Reasonable and Customary**" (R&C) means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.
Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date.

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

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

Accidental Death & Dismemberment Benefits

The Company will pay the benefit below for Injuries to a Covered Person
(a) caused by an Accident which happens while a Covered Person is covered by the Policy; and
(b) which directly, and from no other cause, result in any of the losses listed below within 180 days of the Accident that caused the Injury.
The amount of this benefit is shown in the following table:

For Loss of	Percentage of Maximum Amount
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
One Hand or One Foot	50%
The Sight of One Eye	50%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint.
"Loss" of sight of an eye means the total, irrevocable loss of the entire sight in that eye.
"Severance" means the complete separation and dismemberment of the part from the body.
If a Covered Person suffers more than one loss as a result of the same Accident, the Company will pay only for the loss with the largest benefit.

Coordination of Benefits

Benefits will be coordinated with any other group medical, surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

Mandated Benefits

Maryland mandates coverage for the following benefits to be paid on the same basis as any other Sickness: Diabetes, Home Health Care, Mammography Screening, Colorectal Cancer Screening, Reconstructive Breast Surgery, Prostate Cancer Screening, Child Hearing Aids, Medical Foods, Osteoporosis Prevention & Treatment, Chlamydia & HPV Screening Test, Dental Anesthesia, Child Wellness Services, Clinical Trials, Residential Crisis Services, Habilitative Services for Children, Hair Prosthesis, Treatment Of Morbid Obesity, and In Vitro Fertilization, Mental Illness And Substance Abuse, and any other applicable mandates. Please see the complete Policy on file with the University for full details.

SCHEDULE OF BENEFITS

The Plan Pays Eligible Expenses up to the maximum benefit for each service as scheduled below.

Policy Year Plan Maximums:	Student: 100% of Eligible Expenses up to $5,000, then 80% of Eligible Expenses to a plan maximum of $200,000 per Injury or Sickness Dependent: 100% of Eligible Expenses up to $5,000, then 80% of Eligible Expenses to a plan maximum of $50,000 per Injury or Sickness.
Plan Deductible per Covered Person	$100 Deductible per Policy Year
BENEFIT TYPE:	**COVERAGE PROVIDED:**
INPATIENT HOSPITAL SERVICES	
Hospital Expenses, daily semi-private room rate, general nursing care, Hospital Miscellaneous Costs such as the cost of the operating room, lab tests, x-ray exams (including professional fees), anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services and supplies.	R&C / maximum of $2,000 Aggregate per Day
Routine Newborn Care while hospital confined and routine nursery care provided immediately after birth (48 hours for vaginal birth and 96 hours for cesarean delivery maximum).	Paid as any other Injury or Sickness.
Physiotherapy	R&C
Surgeon's Fees—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 subsequent procedures.	R&C
Anesthesia, professional services in connection with inpatient surgery.	R&C
Registered Nurse's Services, private duty nursing care.	R&C / $50 per day
Doctor's Visits, benefits are limited to one visit per day and do not apply when related to surgery.	R&C
Pre-Admission Testing, payable if performed within 3 working days prior to admission.	R&C
OUTPATIENT SERVICES	
Surgeon's Fees—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 subsequent procedures.	R&C
Day Surgery Miscellaneous, related to a scheduled surgery performed in a Hospital or outpatient facility, including the cost of the operating room, lab tests, x-ray exams (including professional fees), anesthesia, drugs (excluding take-home drugs) or medicines, and supplies.	R&C
Doctor's Visits, benefits are limited to one visit per day and do not apply when related to surgery or Physiotherapy.	R&C
Anesthesia, professional services in connection with outpatient surgery.	R&C
Physiotherapy, visits are limited to one per day.	R&C
Medical Emergency Expenses, use of the emergency room and supplies. Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.	R&C
Diagnostic X-Ray & Laboratory Services	R&C / $600 maximum per Injury or Sickness
Tests and Procedures, diagnostic services and medical procedures performed by a Doctor, other than Doctor's Visits, Physiotherapy, x-rays and lab procedures.	R&C
Chemotherapy and Radiation Treatment.	R&C
Prescription Drugs. However obtained, all Outpatient Prescription Drugs are subject to the Outpatient Prescription Drug Maximum. Each prescription/refill is limited to a 30-day supply; mail order is limited to a 90-day supply.	$10 co-pay per Generic / $35 co-pay per Brand Name Drug to a maximum of $500 per policy year for prescriptions filled through the Express Scripts Pharmacy Network.
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS	
Inpatient Treatment	Inpatient—Benefits paid as any other Sickness. Partial Hospitalization—Benefits paid as any other Sickness to a maximum of 60 days per policy year.
Outpatient Treatment	Outpatient Benefits: —Coverage provided at 100% of R&C to a maximum of 24 visits per policy year; then coverage provided at 80% of R&C for an additional 24 visits per policy year. —Maximum coverage provided is 48 visits per policy year.
OTHER HEALTH CARE BENEFITS	
Ambulance Services	R&C / $350 maximum per trip.
Durable Medical Equipment / Orthopedic Braces and Appliances, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	R&C / $5,000 maximum per Injury or Sickness
Dental Injury Treatment, made necessary to injury of sound, natural teeth, and fractured jaw only.	R&C / $200 per tooth / $600 maximum per Injury
Maternity and Complications of Pregnancy	Paid as any other Sickness
Elective Abortion	R&C / $500 maximum per occurrence
Home Health Care	R&C / $75 per day / 40 days maximum per Injury or Sickness
Diagnostic Imaging (CAT Scan, MRI)	R&C / $1,000 maximum per Injury or Sickness
Club Sports	R&C / $5,000 maximum per Injury
ACCIDENTAL DEATH & DISMEMBERMENT	Principal Sum: Student—$10,000; Spouse—$5,000; Child—$1,000

Exclusions and Limitations

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

1. as a result of dental treatment, or dental x-rays except as specifically provided.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student health Service fee.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such); radial keratotomy or laser surgery; or treatment for visual defects and problems. "Visual defects" means any physical defect of the eye which does or can impair normal vision apart from the disease process. Eye refraction is not covered.
4. for 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. This exclusion does not apply to benefits for Child hearing Aid Expense.
5. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
6. for Injury or Sickness resulting from war or act of war, declared or undeclared.
7. as a result of an Injury or Sickness for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law.
8. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstruction after a mastectomy.
11. for preventive treatment, testing, immunizations, medicines, serums, vaccines, vitamins, or anti-toxins, except as specifically provided in the Policy.
12. for Elective Treatment or elective surgery except as specifically provided.
13. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
14. for any services rendered by a Covered Person's immediate family member.
15. for a treatment, service or supply which is not Medically Necessary.
16. as a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
17. for treatment of mental illness and substance abuse except as specifically provided in the Policy.
18. for surgery and/or treatment of acne; acupuncture; gynecomastia; allergy, including allergy testing and anti-toxins; biofeedback-type services; breast implants or breast reduction unless Medically Necessary following a mastectomy; circumcision; family planning, except as specifically provided in the Policy; fertility tests, except as specifically provided in the Policy; hair growth or removal; impotence, organic or otherwise; learning disabilities; Attention Deficit Disorder; nonmalignant warts, moles and lesions; obesity except as specifically provided in the Policy; premarital examinations except as specifically provided in the Policy; sexual reassignment surgery; sleep disorders, including supplies, treatment and testing thereof; smoking cessation, except this exclusion will not apply to benefits for

nicotine replacement therapy; tubal ligation; vasectomy; alopecia; and weight reduction.

19. for routine physical examinations or check-ups, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided in the Policy.
20. for treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted conception; elective sterilization or its reversal, artificial insemination or in vitro fertilization.
21. for organ transplants.
22. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, professional and semi-professional sports activity, including travel to and from the activity and practice; hang gliding; parasailing; sky diving; glider flying; or parachuting.
23. for the services of an assistant surgeon.
24. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational except as specifically provided in the Policy.
25. for treatment by a licensed audiologist or speech pathologist of conditions or disorders of hearing or conditions or disorders of speech, voice or language, speech therapy, occupation therapy and any related diagnostic testing, except as provided by a hospital or rehabilitation facility as part of a covered inpatient stay. This exclusion does not apply to Habilitative Services for Children.
26. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
27. for consultant doctor's fees.

Pre-Existing Conditions

Pre-existing Conditions are not covered for the first 12 months following a Covered Person's effective date of coverage under the Policy. This limitation will not apply if:

(a) the Covered Person has been covered under the Policyholder's prior Policy for 12 consecutive months immediately preceding the effective date of coverage under the Policy; or

(b) the individual seeking coverage under the Policy has an aggregate of 18 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior Creditable Coverage. Credit will be given for the time the individual was covered under the prior Creditable Coverage.

Credit for Prior Coverage: A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under the Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

Creditable Coverage means coverage of the individual under any of the following:

(a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
(b) The federal Medicare Program pursuant to Part A or Part B of Title XVIII of the Social Security Act;
(c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
(d) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;

(e) a medical care program of the Indian Health Service or of a tribal organization;
(f) a state health benefits risk pool;
(g) a health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;
(h) a public health plan as defined by federal regulations; or
(i) a health benefit plan under section 5(e) of the Peace Corps Act.

Repatriation of Remains Benefit

$25,000 Maximum Amount per Covered Person

If a Covered Person suffers loss of life due to Injury or emergency Sickness while outside his or her home country, the Company will pay, subject to the Policy provisions, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount per Covered Person. Eligible Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible. Travel Assist must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Assist in advance.

Emergency Evacuation Benefit

$25,000 Maximum Amount per Covered Person

The Company will pay, subject to the Policy provisions, for Eligible Emergency Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her Emergency Evacuation while outside his or her home country, but not exceeding the Maximum Amount per Covered Person for all Emergency Evacuations due to all Injuries from the same accident or all emergency Sicknesses from the same or related causes. Travel Assist must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable.

The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Assist in advance.

Please refer to TRAVEL ASSIST SERVICES section of this brochure for information on how to contact Travel Assist for medical evacuation and repatriation benefit assistance.

Covered Persons are also entitled to the following services:

TRAVEL ASSIST AND STUDENT ASSIST SERVICES
Procedures on How to Access Travel Assist Services 24-hour Assistance Call Center

How to Contact Travel Assist :

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

When to Contact Travel Assist :

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

Travel Assist is available 24-hours-a-day/7-days-a-week/365-days-a-year.
Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help you should the need arise while you are traveling or away from home. The Travel Assist Services Medical Staff consists of full-time, onsite Registered Nurses and Emergency Doctors who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide to Travel Assist Services when you call:

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

Description of Services

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

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

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

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

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Assist's Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler's behalf. These services include Doctor/dental/Hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains, and insurance/claims coordination.

Medical Assistance:

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

STUDENT ASSIST SERVICES

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

- **Personal Security Assistance:** You can feel safe and secure with Student Assist's Personal Security Assistance at home or while traveling. To activate personal security services, please log on to: www.aig.com/personalsecurity. For initial setup, your login is "**9710760**" and the password is "security".

For more informative details visit Uniformed Services University's personalized web page at www.maksin.com/USU.aspx.

Medical Claim Filing Procedures

Claim forms can be accepted directly from Doctors or facilities if the form includes the name of the Covered Person, Covered Student's school name and/or policy number, Covered Student's identification number, date of service, diagnosis, treatment procedure and itemized billed charges.

Claims are to be submitted to the following address:

Maksin Management Corp
P.O. Box 2647
Camden, NJ 08101-2647

Proof of loss must be furnished within 90 days after the date of such loss. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Questions regarding benefits, eligibility, claims procedures or claims status should be directed to the Claims Administrator:

Maksin Management Corp
P.O. Box 2647
Camden, NJ 08101-2647

Customer Service Telephone: 1-877-775-5430
Email: info@maksin.com
World Wide Web Address:
www.maksin.com/USU.aspx

Questions regarding enrollment and payment should be directed to:

University Health Plans
One Batterymarch Park
Quincy, MA 02169

Toll Free Telephone: 1-800-437-6448
Email: info@universityhealthplans.com
World Wide Web Address:
www.universityhealthplans.com

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

Non-Renewable One-Year Term Insurance

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