

DOMESTIC BASIC INJURY AND SICKNESS INSURANCE PLAN

A Non-Renewable Policy for Domestic Students Attending



UNIVERSITY
OF
LOUISIANA
L a f a y e t t e™

Lafayette, Louisiana 70504

“the Policyholder”

2010-2011 Academic Year

Administrator Policy Number: CHH0071551

Underwriter Reference Number: CAS9499820

Underwritten by:

National Union Fire Insurance Company of Pittsburgh, Pa.,

With its principal place of business in New York, NY

“the Company”

Dear Student:

The administration is making available to the students and their dependents, a plan of Blanket Injury and Sickness Insurance. The coverage is designed to provide benefits for medical expenses arising from an Injury or Sickness including those which occur off campus and during interim vacations. Any questions about the Policy should be directed to:

Macori, Inc.
P.O. Box 2567
Spring, Texas 77383-2567

Toll Free: 1-800-285-8133 • Email: macori@macori.com

- ELIGIBILITY -

All registered undergraduate students taking 7 or more credit hours in the spring and fall (4 hours in summer) and all registered graduate students taking 6 or more credit hours (3 hours in summer) are automatically enrolled in this insurance plan at registration and the premium for coverage is added to their tuition billing. **International Students are not eligible for this coverage, but are eligible for a separate plan.** The insurance coverage described in this brochure is available to part-time students on a voluntary basis. Credit hours earned from on-line correspondence, or television courses do not count toward eligibility for students residing and taking classes outside the State of Louisiana. Except in the case of withdrawal due to Sickness or Injury, any student withdrawing from school during the first 31 days of the period for which he or she is enrolled will not be covered under the Policy and a full refund of premium will be made, less any claims paid. Students who withdraw after such 31 days will remain covered under the Policy and no refund will be made. Macori Administration (the Plan Administrator) should be notified at that time by the student. Students who enroll in the spring and are planning to continue in the following fall semester may be covered in the period between the spring semester and fall semester by paying the appropriate premium during the summer semester enrollment period. Students who enroll in the Plan may secure family coverage. Eligible dependents are the Covered Student's spouse residing with the Covered Student, and unmarried children and grandchildren under twenty-four years of age who are not self-supporting and reside with the Covered Student (older if incapable of self-support due to mental or physical incapacity). Dependents must be enrolled for the same period of coverage as the Insured participant.

- EFFECTIVE DATES AND EXPIRATION DATES -

Coverage becomes effective on the latest of: (a) the Policy Effective Date (*08-15-10); (b) the first day of the coverage term for which the proper premium has been received; or 12:01 A.M. following the date the envelope containing the completed Enrollment Form and proper premium for the period of coverage is postmarked by the U.S. Postal Service. All coverage expires at 11:59 P.M. on the first of these to occur: (a) the Policy Termination Date (8/17/11); or (b) the last day for which any required premium has been paid. Newborn children are covered for Injury or Sickness from

birth until 31 days old or until such time as the infant is well enough to be discharged from a hospital or neonatal special care unit to his or her home, whichever period is longer. Written notification of birth and premium must be received with 31 days after the birth in order for the child to remain continuously insured.

ADDITIONAL BENEFITS

The Plan will pay Eligible Expenses for the following benefits in accordance with Louisiana insurance mandates: Annual Pap Smears/Cervical Cancer Screening; Mammography; Annual Prostate Cancer Screening; Mastectomy; Breast Reconstruction and Prostheses; Bone Mass Measurement/Osteoporosis Screening; Off Label Drugs; Inherited Metabolic Disease; Diabetes Equipment, Supplies and Outpatient Self-Management Training and Education; Hearing Impaired Transliteration Services; Cancer Clinical Trials; Immunizations for Dependent Children; Cleft Lip and Cleft Palate; Dental Anesthesia; Hearing Aids for Dependent Children; Colorectal Cancer Screening; Severe Mental Illness ; and ADD/Hyperactivity.

* 8-15-10 Effective Date for Covered Persons maintaining continuous coverage from the 09-10 Policy who: 1) are enrolling in this Plan (without a break); and 2) who had an 8-15-10 Expiration Date. 8-18-10 Effective Date for new enrollees.

SCHEDULE OF BENEFITS

When the Covered Person’s Injury or Sickness requires treatment by a Doctor, the Company will pay for covered Eligible Expenses incurred up to 52 weeks from the date of the Injury or the date of first medical treatment of a Sickness.

PART A: BASIC INJURY AND SICKNESS BENEFIT		\$2,500 Maximum each Injury or each Sickness, subject to the following limits:	
COVERED SERVICES	INJURY BENEFIT	SICKNESS BENEFIT	
I. Inpatient	LIMITS	LIMITS	
Hospital Room and Board	\$100/day	\$100/day	
Hospital Intensive Care Unit (<i>in lieu of Hospital Room and Board</i>)	\$200/day, up to 10 days	\$200/day, up to 10 days	
Hospital Miscellaneous	Up to \$2,250	Up to \$2,250	
Radiation Therapy	R&C	Up to \$275	
Surgical Expense (<i>Paid at 70th percentile of the MDR Schedule</i>)	Maximum of \$1,200	Maximum of \$1,200	
Anesthetist	25% of Surgical Allowance	\$100 per confinement	
Doctor’s Non-Surgical Visits (<i>Not paid day of surgery</i>)	\$75/visit/only one (1) per day, up to 35 visits	\$75/visit/only one (1) per day, up to 35 visits	
Registered Nurse	R&C	R&C	

SCHEDULE OF BENEFITS, CONTINUED

PART A: BASIC INJURY AND SICKNESS BENEFIT

COVERED SERVICES	INJURY BENEFIT	SICKNESS BENEFIT
II. Outpatient	LIMITS	LIMITS
Ambulatory Surgery Miscellaneous	Up to \$2,250	Up to \$2,250
Surgical Expense (<i>Paid at 70th percentile of the MDR Schedule</i>)	Maximum of \$1,200	Maximum of \$1,200
Anesthetist	25% of Surgical Allowance	Up to \$100
Doctor's Non-Surgical Visits (<i>not paid day of surgery</i>)	\$75/visit; one (1) visit per day; begins with 2nd visit; up to 3 visits	\$75/visit; one (1) visit per day; begins with 2nd visit; up to 3 visits
Physical Therapist/Chiropractor	Paid under Doctor's Non-Surgical Visit	Paid under Doctor's Non-Surgical Visit
Hospital Emergency Room (<i>When medically necessary</i>)	Up to \$125	Up to \$125
Diagnostic X-rays & Laboratory Services	Up to \$450	Up to \$400, not surgically related
Injections (<i>administered in doctor's office</i>)	R&C	No benefits
Student Health Service Benefits—various services may be provided, please inquire at the Student Health Center.		
III. Other		
Ambulance Services (<i>ground service only</i>)	Up to \$175	Up to \$175
Braces and Appliances (<i>when medically necessary</i>)	R&C	No benefits
Consultant Doctor (<i>when requested by attending Doctor</i>)	Up to \$150	Up to \$150
Dental treatment (<i>injury only</i>)	\$150/tooth; up to \$450	No benefits
Mental and Nervous Disorders (<i>inpatient only</i>)	No benefits	Same as any other Sickness
Substance Abuse	No benefits	Paid under Mental & Nervous Disorders
Maternity Benefits	No benefits	Same as any other Sickness
Motor Vehicle Injury	Up to \$1,500	No benefits

SCHEDULE OF BENEFITS, CONTINUED

PART A: BASIC INJURY AND SICKNESS BENEFIT, CONTINUED

III. Other, Continued

Mammography as state mandated based on the following schedule: (1.) One baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age. (2.) One mammogram every twenty-four (24) months for every woman who is forty (40) through forty-nine (49) years of age, or more frequent if recommended by her Doctor. (3.) One mammogram every twelve (12) months for any woman if fifty (50) years of age or older. Paid same as any other Sickness.

PART B: Major medical benefits are coupled with Part A, the Basic Plan, such that once the basic plan has paid \$2,500, the excess incurred expenses will then be paid at eighty percent (80%) of the Reasonable and Customary charges, up to \$15,000, as a result of any one Accident/injury or Sickness. No benefits are payable for mental/nervous disorders or dental treatment.

PART C: ACCIDENTAL DEATH AND DISMEMBERMENT

If, within 100 days from the date of an Accident covered by the Policy, Injury from such Accident results in Loss listed below, the Company will pay the benefit set opposite such Loss. If the Covered Person sustains more than one such Loss as the result of one Accident, the Company will pay only one amount, the largest to which he/she is entitled. The amount will not exceed the Principal Sum which applies for the Covered Person.

Loss of Life.....	\$2,500
Loss of Two Members.....	\$2,500
Loss of One Member.....	\$1,500
Loss of Thumb & Index Finger of the Same Hand.....	\$750

Member means hand, foot or eye. Loss of hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (joints between the fingers and the hand.)

“Severance” means the complete separation and dismemberment of the part from the body.

PART D: PREMIUMS

	Fall Semester 08-18-10 to 01-12-11	Spring Semester 01-13-11 to 06-01-11	Summer Semester 06-02-11 to 08-17-11
Spouse	\$28.00	\$28.00	\$18.00
Each child	\$18.00	\$18.00	\$12.00

Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company’s only obligation is to refund premium less any claims paid. It is the student’s responsibility to make timely renewal payments to avoid a lapse in coverage. Dependents must enroll in the Plan when the student first enrolls in the Plan each Policy Year, and must enroll for the same coverage as the student.

- 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.

“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 services 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.

“Emergency Medical Condition” means a medical condition of recent onset and severity, including severe pain, that would lead a prudent lay-person, acting reasonably and possessing an average knowledge of medicine and health, to believe that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the health of the person, or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, (b) serious impairment to such person’s bodily functions; (c) serious impairment or dysfunction of any bodily organ or part of such person; (d) serious disfigurement of such person.

“Hospital” means a facility which meets all of these tests:

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

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: mental or nervous disorders; or substance abuse. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

"Injury" means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person's effective date of coverage; and (c) occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

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

A service or supply will not be considered as Medically Necessary if:

(a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is experimental/investigational or for research purposes; or (e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

It does not include emergency services necessary to screen and stabilize a Covered Person. Services for such Emergency Medical Condition shall not require any prior authorization before benefits under the Policy become payable. When the benefit payment for such services has been authorized, the Company will not subsequently retract its authorization after benefit payment has been made or reduce payment for an item, treatment or service furnished in reliance upon approval, unless approval was based upon a material omission or misrepresentation about the Covered Person's health condition made by the provider of Emergency Services. For immediately required post-evaluation or post-stabilization services, the Company will be available 24 hours a day, 7 days a week, to facilitate review.

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.

Definitions, continued from page 7

“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 or a pregnancy existing on the Covered Person’s effective date of coverage under the Policy. The Policy does not impose any pre-existing condition exclusion on the basis of genetic information of a Covered Person.

“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.

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

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

“Sickness” means disease, illness or Complication of Pregnancy which begin after the effective date of the Covered Person’s coverage. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

All Sicknesses due to the same or a related cause are considered One Sickness.

- EXCLUSIONS -

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

1. as a result of dental treatment, or dental x-rays except for treatment resulting from Injury to sound natural teeth.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Service fee.
3. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such except for aphakic patients (including lenses required after cataract surgery and soft lenses or sclera shells to treat Sickness or Injury); radial keratotomy or laser surgery; hearing aids; orthodontic braces and orthodontic appliances or prescriptions or examinations for such except as required for repair caused by a covered Injury 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. Vision examinations not related to prescription or fitting of lenses will be covered only when performed in connection with the diagnosis or treatment of Sickness or Injury. Eye refraction is not covered.

4. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline maintaining regular published schedules on a regularly established route. This exclusion does not apply to insured students while taking flight instruction for University credit.
5. for Injury or Sickness resulting from war or act of war, declared or undeclared.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
10. for preventive treatment, testing, medicines, serums, vaccines, vitamins or oral contraceptives except as specifically provided in the Policy.
11. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, illegal occupation, insurrection or civil commotion.
12. as a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury.
13. for treatment of mental and nervous disorders except as specifically provided in the Policy;
14. for the treatment of alcoholism or substance abuse except as specifically provided in the Policy.
15. for any services rendered by a Covered Person's Immediate Family Member;
16. for a treatment, service or supply which is not Medically Necessary.
17. for loss sustained or contracted in consequence of the Covered Person's being intoxicated or under the influence of narcotics unless administered on the advice of a Doctor.
18. for Injury due to being legally intoxicated, as defined by the jurisdiction in which an Accident occurs, while operating a motor vehicle.
19. for orthopedic appliances or braces which are used mainly to protect an Injury so that the Covered Person can take part in interscholastic or intercollegiate sports.

20. for or in relation to orthopedic shoes or devices intended to be placed inside shoes or other footwear.
21. as a result of a motor vehicle Accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place.
22. 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 unless such infertility is a result of Injury or Sickness.
23. 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 sporting events racing or speed contests; skin diving; scuba diving*; hang gliding; parasailing; sky diving; boating; flight in an ultra light aircraft; glider flying; sail planing; parachuting; ballooning; or mountaineering (where ropes or guides are customarily used. *This exclusion does not apply to insured students while taking scuba diving instruction for University credit.
24. for outpatient prescriptions drugs.
25. for treatment of obesity, (except resulting from diabetes), regardless of the history or diagnosis, including, but not limited to the following: weight reduction or dietary control programs, prescription or nonprescription drugs or medications such as vitamins (whether taken orally or by injection), minerals, appetite suppressants, or nutritional supplements and any complication resulting from weight loss treatments or procedures.
26. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
27. for elective treatment or elective surgery.
28. for elective abortions unless otherwise provided in the Policy.

- PRE-EXISTING CONDITION LIMITATION -

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 his or her effective date of coverage under the current Policy; or (b) the individual seeking coverage under the Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage under this 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 this 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 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 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 in regulations promulgated by the commissioner of insurance; or
- (i) a health benefit plan under section 5(e) of the Peace Corps Act.

Creditable Coverage includes continuation or conversion coverage but does not include Accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

COORDINATION OF BENEFITS: The Policy will coordinate benefits with any valid collectible insurance or plan as outlined in the Master Policy, which is available at the Health Center.

Students must complete a College Claim Form. You may file a claim online at www.macori.com/ULL or, College Claim Forms are available at the Student Health Services. See "Note" below.

MAIL CLAIM FORMS TO:

**CLAIMS OFFICE:
Macori Administration
P.O. Box 2478
Spring, TX 77383-2478**

**Telephone: Houston: 281-651-8787 • Outside Houston: 1-800-285-8133
www.macori.com/ULL**

NOTE: Hospital admissions notification recommended.

CLAIM PROCEDURE

When a Covered Person incurs expenses covered by the Policy, he or she may file a claim online at www.macori.com/ULL. Submit all itemized medical bills to Claims Office listed below:

INQUIRING ABOUT CLAIMS/BENEFITS:

CLAIM FORMS MUST BE FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR FIRST TREATMENT FOR SICKNESS.

Claims Office:

Macori Administration

P. O. Box 2478, Spring, Texas 77383-2478

Providers: Houston Area: 281-528-8949 Toll Free: 877-266-7778

Students: Houston Area: 281-651-8787 Toll Free: 800-285-8133

www.macori.com/ULL



P. O. Box 2478, Spring, Texas 77383-2478

Houston Metro: 281-651-8787

Toll Free: 1-800-285-8133

Web Address: www.macori.com

Email: macori@macori.com

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 www.macori.com.

Please keep this brochure as a general summary of the insurance coverage available under Policy Series S3049NUFIC-LA. The Policy on file at the University contains all of the provisions, definitions, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between brochure and Policy, the Policy will govern in all cases.

The Policy is a non-renewable one-year term insurance policy. Similar coverage may be purchased for the following academic year. It is the Covered Student'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.

STUDENT ACCIDENT/SICKNESS INSURANCE DOMESTIC STUDENT IDENTIFICATION CARD

Policyholder: University of Louisiana Lafayette

Underwritten by: National Union Fire Insurance Company of Pittsburgh, Pa.

Administrator Policy Number: CHH0071551

Underwriter Reference: CAS9499820

Student Name _____

Student CLID # _____

KEEP THIS CARD IN YOUR POSSESSION AT ALL TIMES FOR PRESENTATION TO YOUR MEDICAL PROVIDER

Coverage verification and notification of admission:

In Houston: 281-651-8787 • Outside Houston: 800-285-8133



PHCS

PREFERRED PROVIDER ORGANIZATION (PPO):

PHCS Provider Information is available by calling

888-560-7427 or online at www.macori.com/ULL

(See reverse side for claim filing, vision & Emergency Hotline information)