STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

Designed for the Students of

CMU

CENTRAL MICHIGAN UNIVERSITY

2013 - 2014

This insurance plan includes a Preferred Provider Organization (PPO) Provision.

Policy# CASB-50430-419

Underwriting Company:
AXIS Insurance Company
(herein referred to as "the Company")

AXIS

This brochure is a brief description of the Central Michigan University Student Accident and Sickness Insurance Plan.

The exact provisions governing the insurance are contained in the Master Policy issued to Central Michigan University.

FEDERAL ACA NOTICE

Your student health insurance coverage, offered by AXIS Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014.

Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: $500,000 on medical benefits as shown in the Schedule of Benefits.

If you have any questions or concerns about this notice, contact Collegiate Risk Management at 800-922-3420. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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ELIGIBILITY

All undergraduate students taking six (6) or more credit hours (or one hour for the last semester before graduation) and attending classes are eligible to enroll in the Student Accident and Sickness Insurance Plan. All international students and scholars holding J visas are eligible and are automatically enrolled in the Student Accident and Sickness Insurance Plan, unless proof of comparable coverage is furnished. Graduate students taking 4 or more credit hours are eligible to enroll. Medical students are eligible for this coverage and must have medical insurance.

Insured Persons 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 met. If The Company discovers the Eligibility requirements have not been met, its only obligation is to refund the premium.

POLICY PERIOD

Full Term Rate: Coverage for all non-medical school Insured Persons enrolled for the Full Term, Policy will become effective at 12:01 a.m. on August 20, 2013, and will terminate at 12:00 a.m. on August 19, 2014. Medical school students enrolled for the Full Term, Policy will become effective at 12:01 am on July 28, 2013, and will terminate on 12:00 am July 27, 2014.

Fall Semester: Coverage for non-medical school Persons enrolled for the Fall Semester will become effective at 12:01 a.m. on August 20, 2013, and will terminate at 12:00 a.m. on January 6, 2014. Medical school Insured Persons enrolled for the Fall Semester will become effective at 12:01 am on July 28, 2013 and will terminate at 12:00 am on December 31, 2013.

Spring/Summer Semester: Coverage for all non-medical school Insured Persons enrolled for the Spring/Summer Semester will become effective at 12:01 a.m. on January 7, 2014, and will terminate at 12:00 a.m. on August 19, 2014. Medical school Insured Persons enrolled for the Spring/Summer Semester will become effective at 12:01 am on January 1, 2014 and will terminate at 12:00 am on July 27, 2014.

Summer only: Coverage for all non-medical school Insured Persons enrolled for the Summer only will become effective at 12:01 a.m. on May 12, 2014 and will terminate at 12:00 a.m. on August 19, 2014.

Coverage terminates on the above stated termination dates or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured Person or extend beyond that of the Insured Person.

You must meet the eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse of coverage, your premium must be received within 31 days after the coverage expiration date.

DEPENDENT COVERAGE

An Insured Person may also purchase Dependent coverage. "Dependent" means: (a) the Insured Person's spouse; or (b) the Insured Person's Children under the age of twenty six.

Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already covered for dependent coverage when the child is born. If the Insured Person does not have dependent coverage when the child is born, The Company will cover the

newborn child for dependent benefits from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption. To continue the newborn child's dependent benefits past the first 31 days, the Insured Person must notify the Company, in writing, within 31 days of the child's birth.

The term "children" means

1. A child from birth up to 26 years old.
2. An unmarried child who is 26 or more years old but less than 28 years old who is a resident of this state or a full time student at an accredited public or private institution of higher learning and the child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.
3. A child who is 26 or more years old, primarily supported by the Insured Person, and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the Company within 31 after the date the child ceases to qualify as a Dependent Child for the reasons listed above. During the next two years, the Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Company may require proof no more than once a year.

A Dependent Child, for purposes of this definition, includes Insured Person's:

1. Natural child;
2. Adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. Stepchild;
4. Child for whom the Insured Person is legal guardian

Within 31 days after the child reaches the age of 26, the Insured Student must send us proof of the child's dependency or handicap. The Company may ask for more proof of the child's dependency and handicap, but the Company will not ask for proof more frequently than annually after the two year period following the child's attainment of the age of 26. Proper notice will be furnished to the Insured Person by the Company as to the amount of any additional premium for such child's coverage.

Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.

PREMIUM RATES

	Full Term	Fall	Spring/Summer	Summer
Student	**$2,027**	**$845**	**$1,183**	**$507**
Spouse	**$3,763**	**$1,568**	**$2,196**	**$941**
Each Child	**$2,832**	**$1,181**	**$1,653**	**$709**

ENROLLMENT DEADLINE
Voluntary Coverage

You must submit the enrollment form and premium payment to Collegiate Risk Management; P.O. Box 850001; Orlando, FL 32885-0789 by September 30, 2013 to be covered for either the full policy term

or the fall semester. To be eligible for coverage in the Spring/Summer 2014 semester, your completed enrollment form and premium payment must be received by Collegiate Risk Management no later than February 15, 2014. To be eligible for coverage in the Summer 2014 semester, your completed enrollment form and premium payment must be received by Collegiate Risk Management no later than June 17, 2014.

PREMIUM REFUND POLICY

Insured Persons entering the Armed Forces of any country will not be covered under the Plan as of the date of such entry. Those students withdrawing from the school to enter military service will be entitled to a pro rata refund of premium upon written request. No other refunds are allowed.

EXTENSION OF BENEFITS

If on the date that an Insured Person's coverage under the policy will otherwise terminate due to termination of the Policy, such person is Totally Disabled or Hospital confined, We will continue coverage for expenses incurred for Medically Necessary treatment of the Sickness or covered Injury causing the Total Disability until the earlier of 90 days after the date of Accident causing the injury or the date the Sickness if first treated under the Policy or beyond release from the Hospital for that Inpatient confinement or the limit of liability under this Policy.

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

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

DEFINITIONS

Whenever used in this Policy:

Covered Expense means charges that are Medically Necessary and that are:

1. Not in excess of the maximum amount payable for services as specified in the Schedule of Benefits;
2. In excess of any Deductible amount; and
3. Incurred while the Insured Person's coverage under this Policy is in force.

Insured Person means an Eligible Person, as defined in the Schedule of Benefits, for whom the required premium has been paid when due and for whom coverage under this Policy remains in force. May include Covered Spouse and/or Insured Dependent covered under this Policy.

Injury means bodily injury caused by an Accident. The Accident must occur while the Insured Person's insurance is in force under this Policy. All Injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of an Accident covered under this Policy and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

Medically Necessary means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

a) it is provided only as a convenience to the Insured Person or provider;
b) it is not the appropriate treatment for the Insured Person's diagnosis or symptoms;
c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Physician means a licensed health care provider and/or Licensed Therapist practicing within the scope of his license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:

1. the Insured Student;
2. an Immediate Family Member of either the Insured Person or the Insured Person's spouse;
3. member of the same household.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

Usual and Customary Charge means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

UNIVERSITY HEALTH SERVICE

The Insured Person and the Insured Person's Dependent spouse **must use the resources of the Central Michigan University Health Service (UHS) first where treatment will be administered**.

When services are rendered at the UHS, the deductible will be waived and covered procedures will be payable at 100% of billed charges to $5000. Insureds are responsible for a $10 Co-pay per visit at the UHS.

For services rendered outside of the UHS, no benefits will be paid until the $250 deductible has been met. Once that deductible has been met, the policy will pay 80% of Preferred Allowance in Network and 60% of Usual and Customary Charges Out of Network after applicable Co-pays listed in the Schedule of Student Accident and Sickness Benefits.

Dependent children under the age of 14 are not eligible to use the UHS; and therefore, are exempt from the above limitations or requirements.

PREFERRED PROVIDER NETWORK

The Central Michigan University Student Accident and Sickness Insurance Plan provides access to hospitals and health care providers locally through the Preferred Provider Organization of Cofinity (within the state of Michigan and Beechstreet outside of Michigan), accessed

through PHX (formerly known as National Health Benefits Corp). The advantage to using a Preferred Provider is that these providers have agreed to accept a predetermined fee or preferred allowance as payment for their services. Consequently, when Insured Persons use Preferred Providers, Out-of-Pocket expenses will be based on a preferred allowance. The Insured Person should be aware that Preferred Provider Hospitals may be staffed with Non-Preferred Providers. It is important that the Insured Person verify that his or her Physicians are Preferred Providers each time he or she calls for an appointment or at the time of service. The most efficient and accurate way to identify Cofinity Preferred Providers is by visiting the NHBC web site at **http://providers.nhbc.com. Your access code is AMA915.**

Preferred Provider means the providers and Hospitals who have contracted with the Preferred Provider Organization to provide specific medical care at negotiated prices.

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

Non-Preferred Provider means any Hospital, Physician, or other provider of health care services who has not agreed to any pre-arranged fee schedules.

PRESCRIPTION BENEFIT: CATAMARAN (FORMERLY CATALYST RX)

After a Co-payment of $15.00 for generic (Tier 1) or $40.00 for a brand name (Tier 2) per prescription, the cost of prescription drugs is paid in full. Prescriptions must be filled at the Central Michigan University Pharmacy Service while on campus or a Catamaran participating pharmacy if away from campus. Insured Persons will be given an insurance ID card to show to the Pharmacy as proof of coverage. Central Michigan University Health Pharmacy Services is a participating Catamaran pharmacy.

Before you receive your insurance ID card, if you need to have a prescription filled, you must pay for the medication in full and save the receipt.

Reimbursement will be at the Catamaran contracted discount rate and will be less than the rate charged by the pharmacy. Not all medications are covered. To file for reimbursement, you will need to complete a Prescription Reimbursement Claim Form.

To obtain a form:

- *log on to www.collegiaterisk.com*
- *type in CMU in school name*
- *click on Prescription Claim Reimbursement Form*
- *Download form and mail form along with cash register receipt and Prescription copy to address on the bottom center of the form.*

You may contact Catamaran for a list of participating pharmacies and covered medications or exclusions at 1-800-207-2568 or you can log on to www.mycatamaranrx.com.

After you receive your insurance ID card, no claim forms need to be completed. After you receive the card you may call the toll free customer service number listed on your insurance ID card for assistance with pharmacy locations (800-207-2568). The number is effective for enrolled members only. You will need the Group Number and Member Number printed on your insurance ID card.

Mail order Prescription Drugs are available at 2.5 times the retail co-pay up to a 90 day supply.

DESCRIPTION OF BENEFITS

Payment will be made for Covered Expenses incurred for any one Accident or any one Sickness while covered under the Plan, not to exceed Policy Year Maximum of $500,000. The payment of any Co-pays, Deductibles, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the Insured Person.

To maximize your savings and reduce out-of pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the lower rates these providers have agreed to accept as payment for their services. A Non-Preferred Provider is subject to Usual and Customary Charges maximums. Any charges in excess of the Usual and Customary Charges are not covered under the Plan. A complete listing of Preferred Providers is available through the internet at http://providers.nhbc.com.
Your access code is AMA915, or call 1-888-621-7900.

MEDICAL EXPENSE BENEFITS MAXIMUM BENEFITS

In no event will the Company's total payments for the Insured Person or Insured Dependent exceed the Maximum Benefit Amount for the Accident and Sickness Covered Expenses shown in the Schedule of Benefits.

SCHEDULE OF MEDICAL EXPENSE BENEFITS

The following benefits are subject to the Policy limits and exclusions. All coverage is based on Usual and Customary Charges unless otherwise specified.

Policy Maximum: $500,000 per Policy Year - Out of Pocket maximum $5,000 In Network and $10,000 Out of Network.

Deductible: The Insured Person is responsible for a $250 Preferred Provider deductible per Policy year and a $250 Non-Preferred Provider Deductible per Policy year.

Note: The Policy Deductibles in this plan are separate for Preferred Providers and Non-Preferred Providers, and satisfaction of one Policy Deductible **does not** apply to the other.

Services provided by the University Health Services (UHS) will be paid at 100% of billed charges to $5,000. The deductible does not apply for services rendered at the UHS. There is $10 Co-pay per visit at the UHS.

Dependent children under age 14 are not eligible to use the UHS.

Co-insurance: Except as otherwise indicated, Covered Expenses incurred within the Preferred Provider Network are paid at 80% of the Preferred Allowance. Except as otherwise indicated, Covered Expenses incurred at a Non-Preferred Provider are paid at 60% of the Usual and Customary Charges.

Co-payments: As shown in the Schedule of Student Accident and Sickness benefits beginning on page 7.

Each Insured Person is responsible for the payment of their Deductible. The Deductible and any applicable Co-pays must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

SCHEDULE OF STUDENT ACCIDENT AND SICKNESS BENEFITS

PA = Preferred Allowance

U&C = Usual and Customary Charges

INPATIENT	Preferred Providers	Non-Preferred Providers
*Room and Board Expenses Intensive Care Unit Semi-Private Room	$500 Co-pay per visit then 80% of PA	$500 Co-pay per visit then 60% of U&C
*Hospital Miscellaneous Expenses	80% of PA	60% of U&C
*Inpatient X-ray, CT scan, MRI, laboratory tests	80% of PA	60% of U&C
*Pre Admission Testing	Expenses paid under Hospital Miscellaneous	Expenses paid under Hospital Miscellaneous
*Surgery	80% of PA	60% of U&C
*Assistant Surgeon	25% of Preferred Surgeon's Allowance	25% of U&C Surgeon's Charge
*Anesthesia and its Administration	80% of PA	60% of U&C
*Second Opinion or Consultation	80% of PA	60% of U&C
*Physician In-Hospital Visits 1 visit per day	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Non-Preferred Providers
*Outpatient Surgeon Fees	$500 Co-pay per visit then 80% of PA	$500 Co-pay per visit then 60% of U&C
*Assistant Surgeon	25% of Preferred Surgeon's Allowance	25% of U&C Surgeon's Charge
*Outpatient/Ambulatory Surgery Expense	$500 Co-pay per visit then 80% of PA	$500 Co-pay per visit then 60% of U&C
*Anesthesia and its Administration	80% of PA	60% of U&C
*Emergency Room Services (deductible waived if admitted)	$150 Co-pay per visit then 80% of PA	Paid the same as Preferred Provider
*Non-Emergency Use of the Emergency Room	$250 Co-pay per visit then 80% of PA	$250 Co-pay then 60% of U&C Charges
*Physician Office Visits	$25 Co-pay then 80% of PA	$25 Co-pay then 60% of U&C Charges

OUTPATIENT CONT'D	Preferred Providers	Non-Preferred Providers
Chiropractic Office Visits Maximum 20 visits per year	$40 Co-pay then 80% of PA	$40 Co-pay then 60% of U&C Charges
*Outpatient X-Ray, CT Scan, MRI and Laboratory Tests	80% of PA	60% of U&C
*Radiation Therapy and Chemotherapy	80% of PA	60% of U&C
*Outpatient Physiotherapy Maximum 20 visits per year	$40 Co-pay then 80% of PA	$40 Co-pay then 60% of U&C Charges

ADDITIONAL BENEFITS	Preferred Providers	Non-Preferred Providers
*Ambulance Services	80% of PA	60% of U&C
*Medical Equipment Rental	80% of PA	60% of U&C
*Diabetes Self Management/Supplies	80% of PA	60% of U&C
*Outpatient Prescription Drugs	$15 Co-pay Generic Drugs per 31 day supply $40 Co-pay Brand Drugs per 31 day supply	60% of U&C
*Prosthetic Appliances and Orthotic Devices	80% of PA	60% of U&C
* Home Health Care, Minimum Hospital Stay: 5 consecutive days * Home Health Care must begin within 5 consecutive days after the minimum hospital stay * Maximum 60 visits per year	$40 Co-pay then 80% of PA	$40 Co-pay then 60% of U&C
*Rehabilitation Care Facility	80% of PA	60% of U&C
*Skilled Nursing Facility Maximum days per year 60	80% of PA	60% of U&C
*Urgent Care Center	$40 Co-pay then 80% of PA	$40 Co-pay then 60% of U&C
*Colorectal Exam Deductible does not apply	100% of PA	100% of U&C
*Pelvic & Cervical screening Deductible does not apply	100% of PA	100% of U&C

ADDITIONAL BENEFITS CONT'D	Preferred Providers	Non-Preferred Providers
*Mental & Nervous Disorder, including behavioral health services *Hospital Expenses Inpatient Expenses Benefit Maximum: 45 days per Policy Year *Outpatient Physician Expenses Benefit Maximum: 45 visits per Policy Year	80% of PA	60% of U&C
*Maternity & Newborn Coverage (including Complications of Pregnancy)	Paid as any other Sickness	Paid as any other Sickness
*Preventative Adult Benefit	100% of PA	100% of U&C
*Allergy Treatment Expense Benefits	80% of PA	60% of U&C
*Preventative Child Care Benefit Deductible does not apply	100% of PA	100% of U&C
*Durable Medical Equipment	80% of PA	60% of U&C
Student Health Center	Included	

MANDATED BENEFITS	Preferred Providers	Non-Preferred Providers
*Antineoplastic Therapy	80% of PA	60% of U&C
*Breast Reconstruction After Mastectomy Benefit	80% of PA	60% of U&C
*Diabetes	80% of PA	60% of U&C

MANDATED OFFERS	Preferred Providers	Non-Preferred Providers
*Substance Abuse Treatment Benefit	80% of PA	60% of U&C

* Denotes an "Essential Benefits" as defined by the Affordable Care Act

PREVENTATIVE CARE - ADULTS

The Company will pay the Covered Expenses incurred for adult preventative health care services for Insured Person as shown in the Schedule of Benefits. Benefits for adult preventative health care services are exempt from any Co-payment, deductible, or dollar limit provisions in the Policy.

Definitions:

Preventative Care means Physician-supervised services for eligible Insured Persons over the age of eighteen (18), as recommended by the United States Preventative Services Task Force (USPSTF) with a grade of A or B; any recommended immunizations by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention or the Health Resources and Services Administration (HRSA).

PREVENTATIVE CARE - CHILD

The Company will pay the Covered Expenses incurred for child preventative health care services for an Insured Dependent as shown in the Schedule of Benefits. Benefits for child preventative health care services are exempt from any Co-payment, deductible, or dollar limit provisions in the Policy.

DEFINITIONS:

Preventative Care means Physician-delivered or Physician-supervised services for eligible Insured Persons through the age of eighteen (18), as recommended by the United States Preventative Services Task Force (USPSTF) with a grade of A or B; Any recommended immunizations by the Advisory Committee on Immunization Practices (AICP) that have been adopted by the Director of the Centers for Disease Control and Prevention or the Health Resources and Services Administration (HRSA).

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

If such Injury shall, independently of all other causes and within 180 days from the date of Injury, solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below. Payment under this benefit will not exceed the policy maximum benefit.

For Loss of:

Life $5,000
Two or more members.....$5,000
One member $2,500

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

COORDINATION OF BENEFIT PROVISION

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.

STATE MANDATED BENEFITS

This Plan also covers all mandated benefits as required by the state in which this Policy is issued 80% of Preferred Allowance for Preferred Providers or 60% of Usual and Customary Charges for Non-Preferred Providers, except as otherwise stated.

Antineoplastic Therapy Benefit

The Company will pay the Covered Expenses incurred by a Insured Person for antineoplastic therapy and the cost of its administration. Coverage under this section is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

1. The drug is ordered by a Physician for the treatment of a specific type of neoplasm;
2. The drug is approved by the FDA for use in antineoplastic therapy;

3. The drug is used as part of an antineoplastic drug regimen;
4. Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and
5. The Physician has obtained informed consent from the patient for the treatment.

The Company will pay the Covered Expenses in the same way as the Company treats Covered Expenses for any other Sickness.

Breast Reconstruction After Mastectomy

The Company will pay the Covered Expenses incurred if an Insured Person who is receiving benefits under the Policy in connection with a mastectomy elects breast reconstruction in connection with such mastectomy.

For purposes of this Benefit, Covered Expenses include those expenses incurred for:

1. Reconstruction of the breast on which the Mastectomy has been performed;
2. Surgery and reconstruction of the non-diseased breast to restore and achieve symmetry;
3. Prosthetic Devices and treatment of physical complications for all stages of a Mastectomy, including lymphedema (swelling associated with the removal of lymph nodes); and
4. Hospitalization, for a length of stay as determined by the attending Physician and surgeon in consultation with the Insured Person, and consistent with sound clinical principles and processes

The Company will pay the Covered Expenses to the same extent as any other covered Sickness.

Definitions

Coverage for Prosthetic Devices or Reconstructive Surgery means any initial and subsequent reconstructive surgeries or Prosthetic Devices, and follow-up care deemed necessary by the attending Physician.

Prosthetic Devices means the provision of initial and subsequent devices pursuant to an order of the patient's attending Physician.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons, as determined by a licensed Physician.

To Restore and Achieve Symmetry means that, in addition to Coverage for Prosthetic Devices or Reconstructive Surgery for the diseased breast on which the Mastectomy was performed, Prosthetic Devices and reconstructive surgery for the healthy breast is also covered if, in the opinion of the attending Physician, this surgery is necessary to achieve normal symmetrical appearance.

Diabetes Self-Management and Supplies

The Company will pay the Covered Expenses incurred for Physician prescribed Medically Necessary equipment, supplies and self-management training used in the management and treatment of Diabetes.

Definition:

Diabetes means an Insured Person with gestational, type I or type II diabetes.

Mammography Expenses for Mammographic Exams

Benefits will be paid for mammographic exam as follows:

a) One baseline Mammogram for a woman 35 through 39 years of age;
b) One Mammogram every 24 months for a woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a Physician;
c) One Mammogram every 12 months for a woman 50 years of age or older;
d) A Mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer.

Expenses are not subject to the Deductible.

For purposes of this benefit:

Mammogram means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.

Substance Abuse Treatment Benefit

The Company will pay the Covered Expenses incurred by an Insured Person for Inpatient Care and Intermediate and Outpatient care for Substance Abuse.

We will pay the Covered Expenses incurred by a Insured Person for the Inpatient Care of Substance Abuse as agreed upon by the Policyholder and the Company. What the Company will pay for Inpatient Care is shown in the Schedule of Benefits.

The Company will also pay the Covered Expenses in the same way as the Company treats Covered Expenses for any other Sickness. What the Company will pay for Intermediate and Outpatient care is shown in the Schedule of Benefits.

For Purposes Of This Benefit:

Inpatient Care means treatment received in a facility approved by the Department of Public Health for hospitalization or treatment of Substance Abuse.

Intermediate and Outpatient Care means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

1. Chemotherapy;
2. Counseling;
3. Detoxification services; and
4. Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

Substance Abuse means that term as defined in section 6107 of Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

TRAVEL ASSISTANCE SERVICES

The following Travel Assistance, Emergency Medical Evacuation/ Repatriation, bedside visit by family member or friend and Repatriation of Mortal Remains benefits are provided by Europ Assistance (EA-USA)

WHAT IS TRAVEL ASSISTANCE?

Your travel assistance program is designed to help you along the way before and during your travels. If you encounter a medical or other emergency during your trip of 90 days or less when you are at least 100 miles away from home, emergency assistance is available to you any time of day. Information services (such as "Cultural Information" details about a location you are planning to visit, visa or passport information, etc) are available at any time, even if you don't travel.

ABOUT THE SERVICE PROVIDER

Founded in 1963 Europ Assistance (EA-USA) was the first company to offer assistance services to travelers. Now, EA-USA provides help to customers throughout the world utilizing 36 assistance centers operating around the clock. Further support comes from an extensive international provider network and local agents in over 200 countries and territories allowing EA-USA to offer local support in virtually any location. Headquartered in Bethesda, Maryland just outside of Washington, DC, EA-USA's International Assistance Coordinators, Case Managers, doctors and nurses are available 24 hours a day to take care of virtually any assistance need. EA-USA may be reached by phone at 800-961-2755 (toll free) or at their website, www.europassistance-usa.com. Ask for: STUDENT TRAVEL ASSIST

KEY SERVICES
EMERGENCY MEDICAL TRANSPORTS

Should the patient's conditions require a medical transport based on the evaluation and recommendation of one of EA-USA's physicians, EA-USA will take care of all required arrangements to either move the patient to the needed level of medical care ("evacuation") or return him/her to his/her place of residence for the purpose of recuperation, rehabilitation or further care("repatriation").

EA-USA will pay up to $1,000,000 CSL ("Combined Single Limit" for all transport related eligible expenses).

All services must be arranged by EA-USA at 1-800-961-2755

REPATRIATION OF MORTAL REMAINS

In the event an Insured Person dies, EA-USA will arrange for the deceased to be returned to their place of residence for the purpose of burial or cremation. EA-USA will also take care of ancillary requirements such as government authorization, death certificates as governed by the policy. EA-USA will pay up to $1,000,000 CSL for eligible transport expenses and ancillary services.

All services must be arranged or approved by EA-USA at 1-800-961-2755

BEDSIDE VISIT BY FAMILY MEMBER OR FRIEND

Should the Insured Person be hospitalized for seven or more consecutive days, be likely to be hospitalized for seven or more days or is in critical condition, EA-USA will arrange and pay for the economy class round-trip transportation of one family member or friend from his/her home to the place where the insured person is hospitalized. EA-USA will pay for eligible expenses up to $1,000,000 CSL.

The benefit includes meals and accommodations reimbursement for up to 5 days with a maximum benefit of $150 per day while visiting the hospitalized Insured Person.

All services must be arranged or approved by EA-USA at 1-800-961-2755.

OTHER BENEFITS:

- Medical Provider Search and Referral
- Medical Monitoring
- Return of Travel Companion Assistance
- Dependent Child Return Assistance
- Emergency Cash Advance (credit card guarantee required)
- Legal Assistance/Bail (credit card guarantee required)
- Prescription Transfer/Shipment of Medication
- Emergency Travel Arrangements (credit card guarantee required)

In all cases, the medical professionals, medical facilities or legal counsel suggested by EA-USA to provide direct services to the eligible person are not employees or agents of EA-USA or AXIS Insurance Company, and the final selection of any such medical professional, medical facility, or legal counsel is your choice alone. Neither EA-USA nor AXIS Insurance Company assumes any responsibility for the quality or content of any such medical or legal advice or services. Neither EA-USA nor AXIS Insurance Company shall be liable for the negligence or other wrongful acts or omissions of any of the healthcare or legal professionals providing direct services pursuant to this Agreement. The Insured Person shall not have any recourse against EA-USA or AXIS Insurance Company by reason of its suggestion of or contract with any medical professional or attorney.

The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, EA-USA may not be able to respond in the usual manner. EA-USA also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, Acts of God or refusal of authorities to permit EA-USA to fully provide services.

24-HOUR NURSE ADVICE LINE

Wouldn't you feel better knowing you could get health care answers from a Registered Nurse 24-hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. EA-USA provides Members with clinical assessment, education and general health information, benefits are provided by EA-USA and are not insured by AXIS Insurance Company. This service shall be performed by a registered Nurse Counselor to assist in identifying the symptoms reported and/or health care questions asked by appropriate level and source(s) of care for members (based or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in the Student Health Insurance Plan in order

to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful healthcare information at 1-800-961-2755 or collect calls at 1-240-330-1495.

AXIS Insurance Company Student Accident and Sickness Insurance Policy Exclusions:

The Policy does not cover any losses caused by, contributed or resulting from, in whole or part, the following, unless specifically provided in the Policy:

1. Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by health care providers employed by the Policyholder;

2. Private duty nursing or skilled nursing services;

3. Nonprescription drugs or medicines;

4. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;

5. Sickness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports, intercollegiate club sports, and professional sports;

6. Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;

7. Cosmetic surgery and procedures, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect;

8. Illness, Accident, treatment or medical condition arising out of hanggliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungicord jumping;

9. Expenses incurred for travel to a Foreign Country, for the purpose of seeking medical care or treatment, except for emergency treatment of an Injury or Sickness;

10. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;

11. Expense incurred as the result of dental treatment, except as specifically provided in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;

12. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;

13. Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community. Also services and supplies in connection with Experimental or Investigational Care for the terminally ill;

14. Injury or Sickness resulting from declared or undeclared war; or any act thereof;

15. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;

16. Injury due to participation in a riot;

17. Charges for which Insured Person have no legal obligation to pay in absence of this or like coverage;

18. Services or supplies rendered by an Immediate Family Member of the Insured Person;

19. Personal hygiene/convenience items; telephone consultations, missed appointments, photocopies or medical records, or completion of claim forms; expenses incurred for custodial care or services not needed to diagnose or treat an Injury or Sickness, including but not limited to services related to the activities of daily living;

20. For services, supplies or treatment, including any period of In-Patient Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Physician; or expenses non-medical in nature;

21. Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; calluses; bunions, except open cutting operations; routine care of toenails, except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet; and any tarsalgia, metatarsalgia. Expenses incurred for the care and treatment of Injury, infection, or disease are not excluded;

22. Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination, and services or supplies for inducing conception;

23. Expenses incurred in connection with any sterilization reversal process;

24. Treatment of obesity, including any care which is primarily dieting or exercise for weight;

25. Marriage, family, and group counseling;

26. Services or supplies primarily for educational, vocational or training purposes, except the initial visit to diagnose and determine if a medical condition is causing a learning disability;

27. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a Injury;

28. Blood plasma, except charges by a Hospital for the processing or administration of blood;

29. Expenses for any service or supply not specified in this Policy as a covered service;

30. An amount of a charge in excess of the Usual and Customary Charge;

31. Elective treatment or elective surgery;

32. 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 scheduled airline maintaining regular published schedules on a regularly established route;

33. For international students, expenses incurred within the Insured Person's Home Country or country of regular domicile;

34. Suicide, attempted suicide, or intentionally self-inflicted injury while sane, or insane;

35. Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Physician;

36. Expense incurred for: breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucus resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism;

37. Voluntary or elective abortion;

38. Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs except as noted, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery; Physician-prescribed Viagra will be limited to six (6) tablets per month;

39. Expense incurred for: moles, non-malignant warts or lesions, fertility medication; legend vitamins or food supplements; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or Hospital, except as provided under the In-patient Hospital Expense Benefit;

40. Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;

41. Testing, treatment, or services for any condition in the absence of Sickness or Injury;

42. Expenses incurred for replacement braces and appliances, except for repair or replacement that is required by a changed condition due to Sickness or Injury. Orthopedic appliances used mainly to protect an injury so that the Insured Person can take part in interscholastic, intercollegiate and club sports;

43. Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;

44. Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;

45. Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Policy, provided they are obtained within four months of the date of the Injury;

46. Services, supplies and facility that are provided mainly for a rest cure, maintenance or custodial care;

47. Expense for hair replacement, wigs or wig maintenance;

48. Subject to the Coordination of Benefits Provision Services that have already been paid by another insurance carrier, even if those services would have otherwise been covered by this Policy;

49. Any treatment, service or supply in excess of the any benefit limit specified in this Policy;

50. Hospital In Patient admissions primarily for diagnostic studies when bed care is not Medically Necessary;

51. Professional services billed by a Physician or Nurse who is an employee of a Hospital or Skilled Nursing Facility, and who is paid by that facility for the service;

52. Patient controlled anesthesia;

53. Hypnosis;

54. Maternity care for a Dependent Child;

55. Health spa or similar facilities: strengthening programs.

SUBROGATION

If the Insured Person is injured or becomes ill through the act of commission of another person, and if benefits are paid under this Policy due to that injury or Sickness, then to the extent the Insured Person recovers for the same injury or Sickness from a third party, his insurer, or the Insured Person's uninsured motorist insurance, AXIS Insurance Company will be entitled to a refund of all benefits it has paid up to the amount of such recovery. Further, AXIS Insurance Company has the right to offset subsequent benefits payable to the Insured Person under the Policy against such recovery.

CLAIM PROCEDURES

In the event of an Injury or Sickness the Insured Person should:

1. Report to the Central Michigan University Health Service (UHS).

2. If away from Central Michigan University, or if the Health Service is closed, consult a Physician and follow his/her advice.

3. Notify, in writing, MCA Administrators, Inc. (MCA); P.O. Box 6540; Harrisburg, PA 17112 within 30 days after the date of the Injury or commencement of the Sickness or as soon thereafter as is reasonably possible. The address for notification is on the back of the brochure or at the top of the Claim Form.

4. Complete the Claim Form in full and sign it. Obtain a Claim Form by visiting www.collegiaterisk.com. Type "CMU" in school name and click on Claim Form. The completed and signed Claim Form should be mailed within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to the Claims Administrator, MCA, at the address on the back of this brochure or on the top of the Claim Form.

5. Itemized medical bills must be attached to the Claim Form at the time of submission. Claims cannot be processed from Balance Due statements. Subsequent medical bills should be mailed promptly to the Plan Manager at the address below. No additional Claim Forms are needed as long as the Insured Persons/ Students name and Social security number are included on the bill.

6. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to MCA at the address on the back of this brochure. Office hours are 8:00 a.m. to 5:00 p.m. (EST) Monday through Friday.

APPEALS

If a claim is wholly or partially denied, a written notice will be sent to the Insured Person containing the reason for the denial. The notice will include a reference to the provision in the Plan description and a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal, along with any additional information or comments, may be sent within 6 months after notice of denial. In preparing the appeal, the Insured Person or his representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.

REMEMBER THAT EACH INJURY OR SICKNESS IS A SEPARATE CONDITION AND REQUIRES A SEPARATE CLAIM FORM.

PRIVACY NOTICE

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AXIS Insurance Company values its relationship with you. Protecting the privacy of the information we have about you is of great importance to us. We want you to understand how we protect the confidentially of information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment of your healthcare.

This privacy policy applies to student health policies underwritten by AXIS Insurance Company. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information (PHI) for the purpose of your treatment, for payment and for health care operations. Not every use or disclosure in a category is listed. However all of the ways that we may use or disclose PHI will fall within one of these categories.

Your Authorization: Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing use or disclosure. You may take away this authorization at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

For Payment: We use and disclose PHI as necessary for payment purposes. For example, we may use your PHI to process a claim or may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and disclose PHI for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your health policy. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To Others: You may authorize us in writing to give your PHI to someone else for any reason. Also, if you are present, and provide authorization, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are unavailable, incapacitated, or facing an emergency medical situation, we may share limited PHI with a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also use or disclose your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared for any purpose as required by law.

We may share PHI with the sponsor of the plan or use in the administration of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

You have the right to obtain a copy and inspect specific items of your PHI, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain PHI, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the PHI you wish to review. We may charge a reasonable fee for access to your PHI.

Amendments to Your PHI

You have the right to request that the PHI we maintain about you be amended or corrected if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Request for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your PHI

You have the right to request an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. Requests must be made in writing. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. The accounting will not include disclosures made prior to June 1, 2011.

Restrictions on Uses and Disclosures of Your PHI

You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us of your request for restriction in writing. We are not legally required to agree to your restriction request but will give each request appropriate consideration.

Confidential Communication of PHI

You have the right to request to receive communications from us regarding your PHI by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health and safety.

Right to a Copy of the Notice - You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Potential Impact of Other Applicable Laws
HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints
If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office of Civil Rights in the U.S. Department of Health and Human Services in Washington, D.C. We will not take action against you for filing a complaint.

Contact Information

If you have questions or need further assistance regarding this Notice, or wish to exercise any of the above mentioned rights, you may write to us at:

Administrative Address:

AXIS Insurance Company
1 University Square Drive, Suite 200
Princeton, NJ 08540
888.870.AXIS (2947)

General questions - please send to:
USSales.AccHealth@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective June 1, 2011

For Questions Call:
Collegiate Risk Management
110 Athens Street
Tarpon Springs, FL 34689
Phone 1-800-922-3420
Email: crm@collegiaterisk.com
Website: www.collegiaterisk.com

Type in "CMU"
on the front page to access
Central Michigan University Information

Notes and Important Numbers

IMPORTANT NUMBERS

THE SINGLE SOURCE FOR ALL OF YOUR INQUIRIES

GENERAL INSURANCE QUESTIONS

Phone 1-800-922-3420

Website……..www.collegiaterisk.com

CLAIMS ADMINISTRATOR

MCA Administrator, Inc
P.O. Box 6540
Harrisburg, PA 17112
1-800-427-9308
Fax: 1-717-652-8328

This brochure is a brief description of the Central Michigan University Student Accident and Sickness Insurance Plan. The exact provisions governing the insurance are contained in the Master Policy issued to Central Michigan University.

This Plan is underwritten by:

AXIS Insurance Company
(herein referred to as "the Company")

Policy# CASB-50430-419