

**2017-2018
STUDENT
INJURY & SICKNESS
BENEFIT PLAN**

**UNIVERSITY OF THE
CUMBERLANDS**

**“the Plan Sponsor”
Williamsburg, Kentucky**

Visit us on the web:

<http://www.ucumberland.edu/insurance>

Claims Administration by:

ARC Administrators

333 W Vine Street

Suite 900

Lexington, KY 40507

Visit **www.arcsvs.com** or

Call 859-721-0799 or

877-309-2955

**UNIVERSITY OF THE CUMBERLANDS
STUDENT INJURY & SICKNESS
BENEFIT PLAN**

This brochure is only a brief description of the coverage available under this Student Injury & Sickness Benefit Plan. The Plan may contain definitions, reductions, limitations, exclusions and termination provisions, some of which may not be included in this brochure. Full details of the coverage are contained in the Plan Document on file at the University. If any discrepancy exists between the contents of this brochure and the Plan Document, the Plan Document will govern in all cases.

ELIGIBILITY

All registered undergraduate international students, and all students participating in intercollegiate athletics are automatically enrolled in the Student Injury & Sickness Benefit Plan. The cost of coverage will automatically be placed on the student's tuition bill. All other students taking credit hours are eligible to purchase this Student Injury & Sickness Benefit Plan coverage on a voluntary basis.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. 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 Student Injury & Sickness Benefit Plan and a full refund of the cost of coverage will be made. Home study, correspondence, Internet and Television (TV) courses do not fulfill the Eligibility requirements that the student actively attends classes. The Student Injury & Sickness Benefit Plan maintains the right to investigate student status and attendance records to verify that the Plan eligibility requirements have been and continue to be met. If the Student Injury & Sickness Benefit Plan discovers that the Plan eligibility requirements have not been or are not being met, its only obligation is to refund the cost of coverage, less any claims paid. A Covered Student must meet the eligibility requirements each time he or she pays the cost of coverage to continue coverage under the Student Injury & Sickness Benefit Plan.

WAIVER PROCESS/PROCEDURE

Students who are currently insured by a health insurance policy, may waive coverage under University of the Cumberland's Student Injury & Sickness Benefit Plan with proof of comparable coverage. The waiver form must be completed and returned to the University of the Cumberland's by the last day of the waiver deadline(s). The waiver deadline for Fall coverage is August 31, 2017; the waiver deadline for Spring coverage is January 31, 2018. If the waiver deadline(s) is ignored, the student will be responsible for the cost of coverage(s). Before the expiration of the waiver deadline each term, no student will be allowed to participate in any intercollegiate athletic activities until their personal health insurance coverage has been verified and approved by the University, or until the student has voluntarily enrolled in this student injury & sickness benefit plan.

OPEN ENROLLMENT PERIOD

Students participating in athletics that are eligible to purchase the coverage under this Plan on a voluntary basis may do so within the open enrollment period. The open enrollment period for Fall coverage ends August 31, 2017. The open enrollment period for Spring coverage ends January 31, 2018. Enrollment forms are available online at <https://www.ucumberlands.edu/insurance/>.

No waiver or enrollment form will be accepted after the waiver deadline. Or, for students enrolling on a voluntary basis, there is no enrollment permitted after the open enrollment period. The only exceptions are the following qualifying events: (1) within 31 days of the date of ineligibility under another Creditable Plan. Proof of the qualifying event must be submitted with the request for enrollment.

MEDICAL BENEFITS SCHEDULE

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Schedule of Benefits: Maximum Plan Benefit: \$25,000 Injury or Sickness. The Plan provides benefits for Eligible Expenses incurred by a Covered Person for loss due to a covered Injury or Sickness up to a Maximum Benefit of \$25,000. Benefits will be paid as allocated for each service as scheduled for the PPO allowable amount for Participating Providers or the level of Usual & Customary for Non-Participating Providers.		
INPATIENT SERVICES		
Hospital Services		
Room and Board: Average daily rate for a semi-private room; general nursing care provided by the Hospital.	100%	75%
Hospital Miscellaneous Expenses: <ul style="list-style-type: none"> • Operating Room • Laboratory Tests & X-Rays • Professional Fees • Anesthesia • Inpatient Drugs • Therapeutic Services • Supplies 	100% \$50 Copayment Per Confinement	75%
Intensive Care Services		
Intensive Care Unit	100%	75%
Routine Well Baby Care		
While Hospital confined and includes routine nursery care provided immediately after birth; up to 4 days Hospital confinement expense maximum.	100%	75%
Inpatient Behavioral Health		
Limited to one visit per day; \$10,000 lifetime maximum benefit; 30 day lifetime maximum.	100%	75%
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 25% of all subsequent procedures.	100%	75%
Assistant Surgeon/Anesthetist		
Professional services rendered in connection with surgery.	100%	75%
Registered Nurse		
Private duty nursing care.	100%	75%
Inpatient Doctor's Visit		
Limited to one visit per day and does not apply when related to surgery.	100%	75%
Inpatient Physical Therapy		
Limited to one visit per day; \$1,000 maximum per Plan Year per Injury or Sickness.	100%	75%

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
OUTPATIENT SERVICES		
<p align="center">Copayments Are Waived For Services Obtained Through Student Health Services Student Health Services Providers Are Listed In This Document See Specific Benefit For Notations Concerning Student Health Services</p>		
Emergency Room Visit		
Medical Emergency; use of Emergency Room and Supplies; treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	100% \$100 Copayment Waived If Admitted	75% \$100 Copayment Waived If Admitted
Urgent Care Center		
Use of Urgent Care facility and supplies. Including Doctor's charges at facility.	100% \$50 Copayment	75% \$50 Copayment
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 25% of all subsequent procedures.	100%	75%
Assistant Surgeon/Anesthetist		
Professional services rendered in connection with surgery.	100%	75%
Outpatient Doctor's Visit		
Copayment Waived If Services Through Student Health Services		
Limited to one visit per day and does not apply when related to surgery.	100% \$20 Copayment	75%
Radiation Therapy/Chemotherapy		
	100%	75%
Allergy Treatment & Testing		
Includes allergy serum	100%	75%
Injections		
Administered in the Doctor's office and charged on the Doctor's statement.	100%	75%
Outpatient Physical Therapy		
Limited to one visit per day; \$50 maximum per day; \$1,000 maximum per Plan Year; per Injury or Sickness; 20 visits maximum per Plan Year per Injury or Sickness.	100%	75%
Tests & Procedures		
Copayment Waived If Services Through Student Health Services		
Diagnostic services and medical procedures performed by a Doctor other than a Doctor's visits. Physical Therapy, X-Rays and laboratory procedures.	100% \$20 Copayment	75% \$20 Copayment
Outpatient Behavioral Health		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Limited to one visit per day; \$1,000 lifetime maximum benefit. For all outpatient expenses related to either a covered Mental and Nervous Disorder or Alcohol and Substance Abuse.	100%	75%
OTHER COVERED SERVICES		
Ambulance Service		
	100%	75%
Durable Medical Equipment		
A written prescription must accompany the claim when submitted; replacement equipment is not covered.	100%	75%
Consultant Doctor's Fee		
When requested and approved by attending Doctor.	100%	75%
Dental Treatment		
Accidental Injury to sound, natural teeth only; \$500 maximum per Plan Year and Per Injury.	100%	75%
Maternity/Complications Of Pregnancy		
	100%	75%
Pap Smear		
One annual for women 18 and older	100%	75%
INTRAMURAL/CLUB/INTERCOLLEGIATE SPORTS		
Covered as any other Injury	100%	75%
PHARMACY BENEFITS		
Outpatient Prescription Drugs		
Requires utilization of the ESI Pharmacy Network. Limited to a 30 day supply per prescription or refill; \$500 aggregate maximum per Plan Year for all Conditions however obtained, all outpatient perscription drugs are subject to the Outpatient Prescription Drug maximum.	Generic: \$15 Copayment Brand: \$25 Copayment	Not Covered

COST OF COVERAGE RATES

	Fall Term 8/7/2017 – 1/8/2018	Spring Term 1/8/2018 – 8/7/2018
Student Only	\$580.00	\$810.00

PLAN EFFECTIVE AND TERMINATION DATES

The University of the Cumberland's Student Injury & Sickness Benefit Plan becomes effective at 12:01 a.m. on August 8, 2017 and terminates at 12:01 a.m. on August 8, 2018. Coverage must be purchased each semester of attendance. Coverage for enrolled Students will be effective on the Plan Effective Date; Effective Date of the coverage period elected; or the day after the date the enrollment form and correct cost of coverage are received, whichever is latest. Coverage under the University of the Cumberland's Student Injury & Sickness Benefit Plan will end for the Covered Person on the earliest of: a) the date the Plan terminates; b) the last day for which cost of coverage has been paid; or c) the date he or she enters the armed forces. Covered Persons entering the armed forces of any country will not be covered under the Plan as of the date of such entry. A pro-rata refund of cost of coverage will be made to such persons upon written request received by the Plan. Refunds of cost of coverages are allowed only upon entry into the armed forces or if Eligibility requirements are not met. No other refunds of cost of coverages will be allowed.

NON-DUPLICATION OF BENEFITS

This Plan provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by any Other Valid and Collectible Insurance. If the Covered Person is covered by Other Valid and Collectible Insurance, all benefits payable by such insurance in excess of \$100 will be determined before benefits will be paid by this Plan. This Plan is the second payor to any other insurance having primary status or no coordination or non-duplication of benefits provision. If the Covered Person is insured under group or blanket insurance which is also excess to other coverage, this Plan pays a maximum of 50% of the benefits otherwise payable. Benefits paid by this Plan will not exceed: (1) any applicable Plan maximums; and (2) 100% of the compensable expenses incurred when combined with benefits paid by any Other Valid and Collectible Insurance.

PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically diagnosed, treated (including medication), or advised by a Physician within the six months immediately prior to his or her Effective Date of Coverage under this Plan.

Covered Medical Expenses resulting from a Pre-existing Condition will not be covered unless:

- (1) twelve consecutive months have elapsed during which no medical treatment or advice is given by a physician for such condition; or
- (2) the Covered Person has been covered under this Plan and the University's prior Plans for six months; or
- (3) the Covered Person has been receiving benefits under the University's prior policies and has been continuously covered since the date of accident, Injury, or Sickness, whichever occurs first.

CERTIFICATE OF CREDITABLE COVERAGE

Coverage under this Plan is "Creditable Coverage" under Federal Law. When coverage terminates, the Covered Person can request a Certificate of Coverage that is evidence of coverage under the Plan. The Covered Person may need such a certificate if he she becomes covered under a group health plan or other health plan within 63 days after the coverage under this Plan 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:

ARC Administrators
333 West Vine Street
Suite 900
Lexington, Kentucky 40507
877-309-2955

PLAN FEATURES AND REQUIREMENTS

The cost containment features listed below are included in the Plan to keep your health care costs more affordable. Please take the time to read the following Plan features and requirements so you will be familiar with your benefits.

The medical benefits stated in this Plan are based upon medical treatment being received from a Preferred Provider Organization (PPO). If a Covered Person seeks treatment from a non-participating provider, benefits will be reduced to the percentage shown in the Schedule of Benefits. Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the Hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or facility to which the Covered Person is referred is also a PPO provider. It is the Covered Person's responsibility to verify that the provider is part of the PPO.

- **Preferred Provider Organization (PPO)**
MultiPlan, PHCS
800-678-7427
www.multiplan.com

The prescription benefits stated in this Plan are based upon prescriptions being filled by a participating pharmacy only. There is no nonparticipating pharmacy benefit. A list of nationwide pharmacies is available for your review via online at www.express-scripts.com. The Prescription Drug Benefit Management services are provided by Express Scripts, Inc. pharmacies.

- **Pharmacy Network**
Express Scripts, Inc.
800-451-6245
www.express-scripts.com

DEFINITIONS

COINSURANCE means the out-of-pocket expenses to be paid by the Covered person as a percentage of the Covered Medical Expenses.

ELECTIVE SURGERY means any surgery or treatment that is not Medically Necessary, including any service, treatment, or supply that is deemed by us to be research or experimental; or is not recognized as generally accepted medical practice in the United States. Elective Surgery and Elective Treatment do not include any procedures deemed a Medical Necessity. Elective Surgery does not mean a Cosmetic Procedure required to correct an Injury for which benefits are otherwise payable under this Plan. Elective Surgery and Elective Treatment includes but is not limited to surgery and/or treatment for acne; acupuncture; bio-feedback type services; birth control; breast implants; breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Plan, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are otherwise payable under this Plan; deviated nasal septum, including submucous resection and/or other surgical correction; family planning; fertility tests; hair growth or removal; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities nonmalignant warts, moles and lesions; obesity and any condition resulting there from (including hernia or any kind), except for the treatment of an underlying covered Sickness; premarital examinations; preventive medicines or vaccines, except where required for the treatment of a covered Injury; sexual reassignment surgery skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing; smoking cessation; temporomandibular joint dysfunction (TMJ); tubal ligation; vasectomy; and weight loss or reduction.

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's coverage is in force under this Plan. A Covered Person must begin receiving services, supplies or treatment within 72 hours from the time of accident in order for it to be considered a covered Injury. 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 loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in death, permanent placement of the Covered Person's health in jeopardy, serious impairment of bodily functions or serious and permanent dysfunction of any body organ or part. Expenses incurred for a medical emergency will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor injuries or minor sicknesses.

MEDICALLY NECESSARY means care which a Physician has determined to be certifiably essential for the diagnosis or treatment of a Sickness or Injury. This determination must be based on objective results produced by an examination of the Covered Person's demonstrable symptoms. The Physician's treatment plan may be reviewed by an impartial third party whose determination will be binding on the Plan and the Covered Person.

MENTAL or NERVOUS DISORDERS means any disorder specified in the diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV, 1995) of the American Psychiatric Association. This will not include conditions not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, V Codes).

OTHER VALID and COLLECTIBLE MEDICAL INSURANCE includes but is not limited to group insurance; automobile medical payments and no-fault insurance; individual major medical policies; coverage provided by a Hospital or medical service organization; union welfare plans; or employer or employee benefits organization; or employer's liability coverage.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. He must be practicing within the scope of his license for the service or treatment given. He may not be the Covered Person or a member of his Immediate Family.

SICKNESS means an illness, or disease, or trauma related disorder due to Injury which causes a loss while this Plan is in force and which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. It also includes Pregnancy and Complications of Pregnancy.

USUAL AND CUSTOMARY CHARGE means the charge which in the Plan's experience is most often incurred for any given procedure. In no event shall the Plan's payment for surgical procedures exceed the Usual and Customary Charges which in the Plan's experience are normally made by the majority of Physicians in that area.

REPATRIATION OF REMAINS BENEFIT \$25,000 Maximum Amount

If a Covered Person suffers loss of life due to Injury or Emergency Sickness while outside his or her home country, the Plan will pay, subject to the Plan limitations, 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. The Plan must authorize all expenses in advance for this benefit to be payable. The Plan reserves the right to determine the benefit payable, including any reductions.

EMERGENCY EVACUATION BENEFIT
\$25,000 Maximum Amount

The Plan will pay, subject to the Plan limitations, for Eligible Emergency Evacuation Expenses reasonably incurred if the Covered Person suffers and 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. The Plan must authorize all expenses in advance for any Emergency Evacuation benefits to be payable. The Plan reserves the right to determine the benefits payable, including reductions.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

For accidental death within 180 days of the date of the accident, or dismemberment within 180 days from the date of covered Injury, the Plan will pay, in addition to the medical benefits provided herein, one of the following:

Event	Benefit
Accidental Death	\$10,000
Two Or More Members	\$10,000
One Member	\$5,000

Only one of the amounts shown above, the largest, will be paid for loss resulting from any one accident, and shall be in addition to any other indemnity payable for such accident. Loss shall mean in regard to Hand or Hands or Foot or Feet, actual severance through or above the wrist or wrists or ankle or ankles, and loss of sight of eye or eyes shall mean the irrecoverable loss of the entire sight thereof.

EXCLUSIONS

- Services and supplies not Medically Necessary for the diagnosis recommended by the attending physician;
- Services that are provided normally without charge by the college's health center, infirmary or Hospital; or by any person employed by the University;
- Declared or undeclared war, civil disorder, civil commotion or acts of terrorism;
- Suicide, attempted suicide or intentionally self-inflicted Injury while sane or insane (in Missouri, while sane);
- Accident sustained or Sickness contracted as a result of the use of alcohol or the misuse of drugs, medicines, or narcotics, unless taken in the dosage and for the purpose prescribed by the Covered Person's Physician;
- Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as fare-paying passenger in an aircraft operated by a commercial scheduled airline. This exclusion does not apply to covered students while taking flight instructions for college credit;
- Injury resulting from racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
- Injury resulting from the playing, practice, participating, or conditioning in any interscholastic, professional, or semiprofessional sport. Injury sustained while traveling to or from such sport, contest or competition as a participant;
- Cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment within 24 hours of the accident. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Plan;
- Pre-marital examinations, pre-employment examinations, health examinations or pre-school physical examinations and related Physician charges;
- Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except as required for repair caused by a covered Injury;
- Dental care by a physician or in a hospital except for multiple extractions or removal of unerupted teeth when a concurrent, hazardous medical condition exists;
- Expenses incurred for manipulation and massage;
- Injury or Sickness for which benefits are payable under any Worker's Compensation or Occupational Disease Law;

- Expenses resulting from a motor vehicle accident for which benefits are payable from other valid insurance;
- Elective Surgery or Elective Treatment;
- Expenses incurred as the result of dental treatment, except as specifically provided for treatment resulting from Injury to natural teeth;
- Injury sustained or Sickness contracted while in the service of the armed forces of any country. When a Covered Person enters the armed forces, we will refund any unearned pro-rata cost of coverage with respect to such person;
- Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
- Homemaking, companion or chronic (custodial) care services. Charges of a home health aide who is a member of your household. Charges of any care provided by relatives (by blood, marriage or adoption);
- Organ transplants;
- Travel in snowmobiles, or on any two, three or four-wheeled off road type motorized or engine-driven vehicles.

CREDIT FOR PRIOR COVERAGE

The Plan provides portability of coverage as it relates to “pre-existing conditions”. The preexisting condition limitation set forth in the Plan will be reduced to the extent a Covered Person was covered under qualifying previous coverage if: 1) the person is not a late enrollee; and 2) the prior coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage, exclusive of any applicable waiting period. Any pre-existing limitation is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the Covered Person as of the enrollment date, for similar services covered under the Plan and the prior coverage.

RIGHT OF SUBROGATION

We will be fully and completely subrogated to the rights of a Covered Person against parties who may be liable to provide indemnity or make a contribution with respect to any matter that is the subject of a claim under the Plan. The Covered Person further agrees to cooperate fully with the Plan in seeking such indemnity or contribution including, where appropriate, when we are instituting proceedings at its own expense against such parties in the name of the Covered Person. The Covered Person further agrees that the Plan will have a lien to the extent of benefits provided. Such lien may be filed with the person whose act caused the Injury, the person’s agent or a court having jurisdiction in the matter.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this Plan ceases on the termination date. However, if a Covered Person is Hospital Confined on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date, Covered Medical Expenses for such Injury or Sickness will continue to be paid until the completion of his Hospital Confinement but not to exceed 90 days from the expiration date of coverage or beyond release from the Hospital for that Inpatient Confinement or the maximum Plan benefit whichever occurs first. If the Covered Person is also a Covered Person under the succeeding Plan Year, this “Extension of Benefits” provision will not apply. After the “Extension of Benefits” provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made. The total payments made in respect of the Covered Person for each condition both before and after the termination date will never exceed the maximum benefit.

CLAIM FILING PROCEDURES

Claims forms can be accepted directly from providers if the claim form includes the name of the Covered Person, name of school under which the Covered Student is Covered Person, identification number, date of services, diagnosis, treatment procedure and billed charges. Proof of loss must be furnished within 90 days after the date of such loss.

Submit Claims to:
ARC Administrators
333 West Vine Street
Suite 900
Lexington, Kentucky 40507

For Claims Inquiries:
ARC Administrators
877-309-2955

Email: info@arcsvs.com

ON-LINE SERVICES

To access the Plan brochure, enrollment cards, I.D. card, secure claim information and other services, please visit the following website: <http://www.ucumberlands.edu/insurance>

NON-RENEWABLE ONE YEAR COVERAGE

This Plan is non-renewable one year coverage. 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 Plan Year.

PLAN SPONSOR, PLAN ADMINISTRATOR, AGENT FOR SERVICE OF LEGAL PROCESS:

University of the Cumberland
Attn: Quentin Young, Vice President of Business Services
6180 College Station Drive
Williamsburg, KY 40769
(606) 539-4209

The Plan Administrator has the discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefit determination. The Plan Administrator's interpretations and determinations are final and binding.

STUDENT HEALTH CENTER OFFICE:

The University of the Cumberland's Student Health Center Office is listed below. The doctors and nurses specified are considered preferred student health center (SHC) providers.

Eddie S. Perkins, D.O. FACOOG
University of the Cumberland's Student Health Clinic
101 Browning Street, Williamsburg, KY 40769
Phone: (606) 539-4575

CLAIMS ADMINISTRATOR:

333 West Vine Street
Suite 900
Lexington, Kentucky 40507
877-309-2955

The Plan is a self-funded plan and is administered directly by the Plan Administrator with claims being paid on behalf of the Plan by the Claims Administrator in accordance with the provisions of the Plan Document:

ARC Administrators
333 West Vine Street, Suite 900
Lexington, Kentucky 40507

The University of the Cumberlands is solely responsible for funding and payment of Benefits under the Plan. ARC Administrators is the designated claims paying agent only and does not insure or underwrite the University of Cumberland's liability under the Plan.

Please keep this brochure as a general summary of the Plan benefits. The Plan Document on file at the University contains all of the provisions, limitations, exclusions and qualifications of your Plan benefits, some of which may not be included in the Brochure. If any discrepancy exists between the Brochure and the Plan Document, the Plan Document will govern and control the payment of benefits.