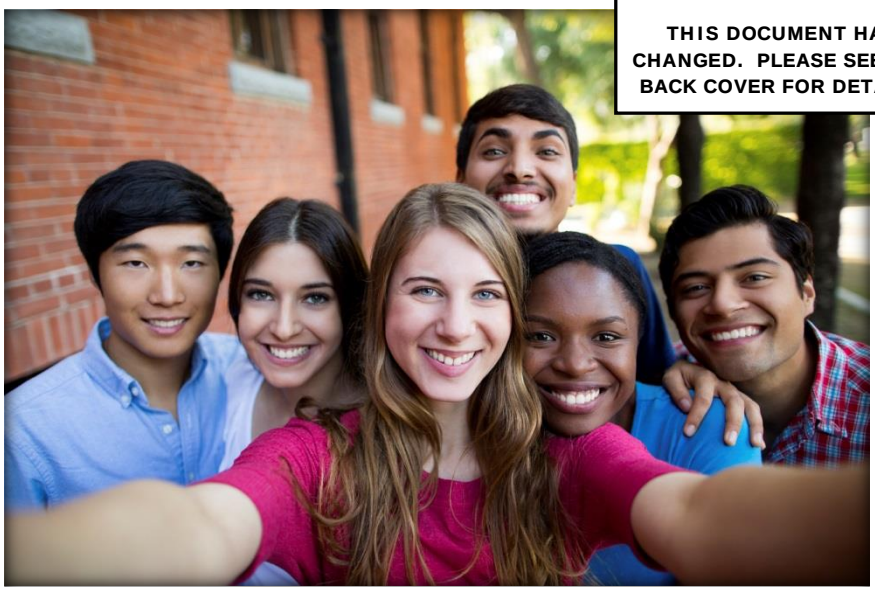
PLEASE NOTE:

THIS DOCUMENT HAS CHANGED. PLEASE SEE THE BACK COVER FOR DETAILS

2016–2017 Student Injury and Sickness Plan for International Students of the Kansas Board of Regents



Who is eligible to enroll?

F-1 International students and J-1 Exchange Visitors are required to have health insurance and must either enroll in this plan or show proof of health insurance coverage in an alternative plan that meets their university's requirements.

Students must attend classes for at least the first 31 days after the start date of the policy. Semester based online courses, home study and correspondence classes do not count. Eligible Dependents (spouses; and children under 26 years of age) of those enrolled in the plan may participate in the plan on a voluntary basis.

Where can I get more information about the benefits available?

Please read the certificate of coverage to determine whether this plan is right for you before you enroll. The certificate of coverage provides details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the coverage may be continued in force.

Who can answer questions I have about the plan?

If you have any questions, please contact Customer Service at 1-888-344-6104, or visit our website at www.uhcsr.com/kbor.

How much does the plan cost?

Rates	Annual 8/1/16 – 7/31/17	Fall 8/1/16 – 12/31/16	Spring 1/1/17 – 5/31/17	Summer 6/1/17 – 7/31/17
Student	$1,392.00	$580.00	$580.00	$232.00
Student + Spouse	$2,784.00	$1,160.00	$1,160.00	$464.00
Student + One Child	$2,784.00	$1,160.00	$1,160.00	$464.00
Student + Two or More Children	$4,176.00	$1,740.00	$1,740.00	$696.00
Student + Spouse + One Child	$4,176.00	$1,740.00	$1,740.00	$696.00
Student + Spouse + Two or more Children	$5,568.00	$2,320.00	$2,320.00	$928.00

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy 2016-200118-4.
The Policy is a Non-Renewable One-Year Term Policy.

Highlights of the Coverage and Services offered by UnitedHealthcare StudentResources		
METALLIC LEVEL GOLD WITH ACTUARIAL VALUE OF 81.644%		
	Preferred Providers	**Out-of-Network Providers**
Overall Plan Maximum	There is no overall maximum dollar limit on the policy	
Plan Deductible	$300 per Insured Person, per Policy Year	$600 per Insured Person, per Policy Year
Out-of-Pocket Maximum *After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any applicable benefit maximums. Refer to the plan certificate for details about how the Out-of-Pocket Maximum applies.*	$6,350 Per Insured Person, Per Policy Year $12,700 For all Insureds in a Family, Per Policy Year	$20,000 Per Insured Person, Per Policy Year $40,000 For all Insureds in a Family, Per Policy Year
Coinsurance *All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan certificate.*	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Customary Charges for Covered Medical Expenses
Prescription Drugs *Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.* *The Deductible does not apply.*	Student Health Center: $5 Copay per prescription for generic prescriptions / 40% Copay for brand name prescriptions UnitedHealthcare Pharmacy (UHCP): $15 Copay per prescription for Tier 1 / 40% Copay for Tier 2 up to a 31-day supply per prescription	$20 Copay per prescription for generic prescriptions / 50% Copay for brand name prescriptions up to a 31-day supply per prescription
Preventive Care Services *Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. No Copay or Deductible when the services are received from a Preferred Provider or the Student Health Center. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.*	100% of Preferred Allowance	No Benefits
The following services have per Service Copays/Deductibles *This list is not all inclusive. Please read the plan certificate for complete listing of Copays/Deductibles.*	Physician's Visits: $25 Copay per visit (waived at the SHC) Lab: $5 Copay at the SHC X-rays: $5 Copay at the SHC Medical Emergency: $100 Copay per visit	Lab: $5 Copay at the SHC X-rays: $5 Copay at the SHC Medical Emergency: $100 Deductible per visit
Pediatric Dental and Vision Benefits	Refer to the plan certificate for details (age limits apply).	
UnitedHealthcare Global: Global Emergency Services	International Students are covered worldwide except in their home country.	

Preferred Providers

The Preferred Provider Network for this plan is UnitedHealthcare Choice Plus. Preferred Providers can be found using the following link: http://www.uhcsr.com/lookupredirect.aspx?delsys=52

Online Services

UnitedHealthcare **Student**Resources Insureds have online access to their claims status, EOBs, ID Cards, network providers, correspondence and coverage account information by logging in to *My Account* at www.uhcsr.com/myaccount. To create an online account, select the "create My Account Now" link and follow the simple, onscreen directions. All you need is your 7-digit Insurance ID number or the email address on file. Insureds can also download our UHCSR Mobile App available on Google Play and Apple's App Store.

NurseLine and Student Assistance

Insureds have immediate access to nurse advice, a health information library, and counseling support 24 hours a day by calling the toll-free number listed on their medical ID card. NurseLine is staffed by both English and Spanish speaking Registered Nurses who can provide health information, support, and guidance on when to seek medical care. The Student Assistance Program coordinates services using a network of resources. Services available include financial and legal advice, as well as mediation. Counseling is also available by Licensed Clinicians who can provide insureds with someone to talk to when everyday issues become overwhelming. Translation services are available in over 170 languages for most services. Insureds also have access to LiveAndWorkWell.com where they can take health risk assessments, use health estimators to calculate things like their target heart rate and BMI, and participate in personalized self-help programs. More information about these services is available by logging into ***My Account*** at www.uhcsr.com/MyAccount.

Exclusions and Limitations:

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acupuncture.
2. Non-medical services, such as but not limited to, legal services, social rehabilitation, educational services, vocational rehabilitation, or job placement services.
3. Learning disabilities.
4. Biofeedback, except:
   - To treat urinary incontinence in adults 18 years and older.
5. Cosmetic procedures or related services, including:
   - Circumcision.
   - Lipectomy.
   - Surgical breast reduction, breast augmentation, breast implants, or breast prosthetic devices, or gynecomastic, except as specifically provided in the policy.
   - Hirsutism.
   - Alopecia.

   This exclusion does not apply to reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Improve or restore impairments of bodily function resulting from Congenital Conditions or developmental anomalies.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
6. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
7. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Elective abortion.
10. Individualized, custom fabricated shoe insert orthotic devices and appliances.
    This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
11. Commercial foot devices available over-the-counter.
12. Routine hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of an infection or Injury.
    - A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
13. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
14. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
15. Injury arising out of a motor vehicle accident to the extent that benefits are payable under any medical expense payment provision of an automobile insurance policy, including such benefits mandated by law.
16. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.
17. Prescription Drugs, services or supplies as follows:

- Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
- Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
- Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs. This exclusion does not apply to drugs for the treatment of cancer that have not been approved by the *Federal Food and Drug Administration* for that indication, if the drug has been prescribed for an Insured Person who has been diagnosed with cancer, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed and is recognized in substantially accepted peer-reviewed medical literature or in one of the following established reference compendia: 1) *The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USPDI)*; 2) *The American Medical Association's Drug Evaluations (AMADE)*l; or 3) *The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI)*. This exception does not provide coverage for any experimental or investigational drugs or any drug which the *Federal Food and Drug Administration* has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.
- Products used for cosmetic purposes.
- Drugs used to treat or cure baldness or for the stimulation of hair growth. Anabolic steroids used for body building.
- Anorectics - drugs used for the purpose of weight control.
- Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

18. Reproductive/Infertility services including but not limited to the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Fertility tests.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
    - Sexual reassignment surgery.
19. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To an Insured Person under age 12 for: a) the initial pair of eyeglasses or contact lenses following cataract surgery, aphakia or pseudophakia; and b) subsequent eyeglasses or contact lenses following cataract surgery when there is a diopter change of .25 diopter.
    - To benefits specifically provided in Pediatric Vision Services.
20. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
21. Preventive care services, except as specifically provided in the policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.
22. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
23. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
24. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
25. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.

NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by UnitedHealthcare. This document is a summary only and may not contain a full or complete recitation of the benefits and restrictions/exclusions associated with the relevant policy of insurance. This document is not an insurance policy document and your receipt of this document does not constitute the issuance or delivery of a policy of insurance. Neither you nor UnitedHealthcare has any rights or responsibilities associated with your receipt of this document. Changes in federal, state or other applicable legislation or regulation or changes in Plan design required by the applicable state regulatory authority may result in differences between this summary and the actual policy of insurance.

POLICY NUMBER: 2016-200118-1

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC# 1 (8/15/2016)
SOB/Prescriptions:
Added "the deductible does not apply" under the line item.

SOB/Preventive Care:
Updated to “No Copay or Deductible when the services are received from a Preferred Provider or the Student Health Center.”