2011-2012

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

University of Illinois at Urbana - Champaign

Undergraduate and Graduate Plans.
Limited Benefit Plan. Please read carefully.

06-BR-IL (Rev 07-07)

12-1351-1/2

Plan I for Undergraduate Students
Plan Number 2011-1351-1

Undergraduate students (as defined herein) of the University of Illinois who are enrolled, in attendance, and assessed all fees are eligible for the Undergraduate Student Injury and Sickness Insurance Plan.

Plan II for Graduate Students
Plan Number 2011-1351-2

Graduate students (as defined herein) of the University of Illinois who are enrolled, in attendance, and assessed all fees are eligible for the Undergraduate Student Injury and Sickness Insurance Plan.

Dependents (as defined herein) of an Insured graduate student are also eligible provided application for coverage is made during enrollment periods.

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling 217-333-0165 or visiting us at: www.si.uiuc.edu.

Introduction

This booklet contains the principal provisions of the Policy which has been given to your University. A copy of that Policy is available for your review at the University. In the event of an inadvertent conflict between the Policy and this booklet, the Policy will prevail. In the event of an inadvertent conflict between the Policy and Federal or State law, the law will prevail.

The University requires that all eligible students be covered by health insurance and provides a Plan for which the fee is automatically assessed along with other tuition and fees. Coverage under the Plan is worldwide. Plan benefits are explained in the following pages. **Plan 1, Policy number 2011-1351-1, is applicable to undergraduate students and their Dependents only. Plan 2, Policy number 2011-1351-2, is applicable to graduate students and their Dependents only.**

The Plan is administered by the University including the processing and payment of claims. The operation of McKinley Health Center is NOT part of the Student Health Insurance Plan, therefore, it is not necessary to be seen or referred by a Health Center Physician in order to receive the benefits of the Student Health Insurance Plan. Referral from the McKinley Health Center does not insure benefits will be paid.

Undergraduate Fee/Premium per semester (Plan I)

Student	$219.00
Spouse of student*	$901.00
Child or all children of student*	$416.00

*(student must also be insured)

The Summer Session is considered a semester; a full semester fee/premium is required regardless of the effective date of insurance for the Student or Dependents.

Graduate Fee/Premium per semester (Plan 2)

Student	$ 310.00
Spouse of student*	$ 1,253.00
Child or all Children of student*	$ 624.00

*(student must also be insured)

The Summer session is considered a semester; a full semester fee/premium is required regardless of the effective date of insurance for the student or Dependents.

2011-2012 Important Dates & Deadlines*

*Deadlines are the dates by which exemptions, extensions, limited enrollment reinstatements or enrollment of Dependents must be accomplished. Students who late register will be given 14 calendar days (Fall and Spring 7 days), from the date of registration, to complete exemptions and applications for Dependent coverage.

Dependents acquired through marriage or birth, including an adopted child, after the above deadline dates may be added for coverage provided application and proper premium is received within thirty-one (31) days after the date of marriage or birth (if the 31 day period encompasses a change in semester, premium will be required for both semesters in order for coverage to be retroactive to the date of the event).

Dependents of international students arriving in the United States after the semester deadline dates may be added for coverage provided application and proper premium is received within thirty-one (31) days of arrival in the United States.

	Fall Semester	Spring Semester	Summer Session
Semester Coverage Periods:	08/21/2011 - 01/13/2012	01/14/2012 - 05/11/2012	05/12/2012 - 08/20/2012
Enrollment/Change Period:	08/22/2011 - 09/23/2011	01/17/2012 - 02/22/2012	05/14/2012 - 06/22/2012
Extension Enrollment Periods & Deadlines:	07/11/2011 - 09/23/2011	12/01/2011 - 02/22/2012	04/11/2012 - 06/22/2012

Eligibility

Students of the University of Illinois who are enrolled, in attendance, and assessed all fees are eligible for the Student Health Insurance Plan. The fee is automatically assessed along with other tuition and fees. Plan 1, Policy number 2011-1351-1, is applicable to undergraduate students and their Dependents only. Plan 2, Policy Number 2011-1351-2 is applicable to graduate students and their Dependents only.

Undergraduate and Graduate students (as defined herein) of the University of Illinois who are enrolled, in attendance, and assessed all fees are eligible for the Student Health Insurance Plan.

Dependents (as defined herein) of an Insured are also eligible provided application for coverage is made during Enrollment Periods detailed below.

Enrollment Periods and Effective Dates

If Insured person, other than newborn, is an Inpatient in a healthcare facility on his/her Coverage Date, such person's Coverage Date will be the date of discharge.

Students assessed the insurance fee are automatically enrolled in this insurance Plan; no application is required and the effective date will be the beginning "Semester Coverage Period" date for the appropriate semester as herein.

Purchase of Insurance for spouse, Domestic Partner and/or children:

Dependent (spouse, domestic partner and/or children) coverage must be applied for each semester during the Enrollment/Change period listed in the Important Dates and Deadlines section. Coverage shall take effect on the date of application and receipt of proper premium by the University of Illinois, or the appropriate semester beginning date, whichever is later. Dependents insured for the prior semester will have no lapse in coverage provided application and premium is received by the appropriate semester deadline date.

If both parents are Insured students, changing child coverage from one parent to the other will not result in a lapse in coverage so long as the application and premium are received by that semester's deadline date. If an individual ceases to be an eligible student but is the Dependent of an Insured student, enrollment for Dependent coverage will not result in a lapse in coverage so long as the application and premium are received by that semester's deadline date.

If an Insured student acquires a Dependent, through marriage or birth, after the listed semester deadline dates, the Dependent is eligible for coverage on the date the Dependent was acquired so long as application and premium payment is made within thirty-one (31) days after the date the Dependent was acquired (if the 31-day period encompasses a change in semesters, premium will be required for both semesters in order for coverage to be retroactive to the date of the event).

Exemption

Exemption from the insurance fee is granted when a student provides evidence of other health insurance coverage, which is in effect on or before the first day of a semester, and equivalent to the University Plan. Acceptable evidence can be an insurance identification card, a copy of the Policy, Plan booklet or letter from the employer or company certifying coverage for the student.

Petitions for Exemption can be completed either in person at the Student Health Insurance Office or by downloading required forms through our Web Site and returning them by U.S. Mail, to the Student Health Insurance Office, 506 S. Wright St. Room 100 A - HAB Urbana, IL 61801, **POSTMARKED NO LATER THAN** the deadline identified in the Important Dates & Deadlines of this booklet.

An exemption will continue in effect until such time as the student requests reinstatement to the Plan, or does not respond to a periodic request to confirm that he or she continues to be covered by another health insurance plan.

Reinstatement

Change of Status Students exempt from the Student Injury and Sickness Insurance Plan who want to be reinstated to the Plan may apply by providing proof of loss of other insurance; i.e., notice of termination of insurance from the insurance company or employer, within sixty-three (63) days of such loss of other insurance. Coverage is effective on the date of application or date of termination of other insurance whichever is later. Student must be registered and eligible to be assessed fee.

Limited Enrollment Students requesting reinstatement more than 63 days after the loss of other insurance, or if no loss of other coverage has occurred, must apply during the Enrollment/Change period of a semester they are eligible for coverage. A pre-existing limitation will be applicable for the first 12 months of coverage (see Pre-Existing Conditions section). Student must be registered and eligible to be assessed fee.

Extension of Coverage for non-registered semesters (Fall, Spring, Summer)

Insured students who do not plan to enroll for classes for the next consecutive semester (summer is a semester) may elect to extend coverage for themselves and for Insured Dependents for one semester beyond the last semester enrolled. Graduating students may elect to extend coverage for two consecutive semesters. Premium for both semesters must be paid at time of application. Applications for extension may be made at the Student Health Insurance office, in person, or by downloading required forms through our website during periods identified as Extension Enrollment Periods listed under the Important dates & Deadlines. Premium is payable at the time of application for extension. More information regarding coverage extensions may be obtained at the Student Health Insurance Office.

Termination of Insurance

The insurance of a student will terminate at 12:00 midnight. (Central Standard time) upon any of the following events, whichever shall first occur:

1. Failure to make premium payment.
2. Entry into the armed forces of any county. With respect to students, membership in the reserves with or without two consecutive full weeks of active training each year shall not be considered as entry into the armed forces.
3. Termination of membership in the class or classes eligible for insurance under this Plan:
   a. With respect to students and Dependents, termination shall occur at the end of period for which premium has been paid. If premium for a specific semester is refunded, coverage for that semester is null and void.
   b. With respect to Dependents, termination of membership shall occur upon ceasing to be a Dependent as defined.
   c. With respect to Dependents reaching the limiting age, coverage will terminate on the first day of the next term.

Termination of a student's insurance shall immediately terminate the Dependents insurance. The discontinuance of the Plan shall immediately terminate all insurance hereunder. Such termination shall be without prejudice to any claim expense originating prior thereto. The discontinuance of any coverage provided hereunder shall immediately terminate the insurance of all Insured Persons with respect to the coverage discontinued except when the covered person is confined in the Hospital on the date coverage would otherwise terminate. In such cases, coverage will continue as described until date of discharge, but not more than ninety (90) days.

Extension of Benefits After Termination

The coverage provided under the policy ceases on the Termination Date. However, if an Insured 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 as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Schedule of Medical Expense Benefits
(Undergraduate Plan 1)
(2011-1351-1)

Maximum Benefit $200,000 (for each Injury or Sickness)
Outpatient Deductible $150 (Per Insured Person) (Per Policy Year)

The policy provides benefits for of Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $200,000 for each Injury or Sickness.

UnitedHealthcare Options PPO Network of Hospitals and health care providers have agreed to accept special reimbursement rates for treatment rendered to Insureds; therefore, use of UnitedHealthcare Options PPO Network of Hospitals and health care providers may result in lower out of pocket expenses.

This plan covers:

1. Injuries incurred while participating in intercollegiate, club and intramural sports (Intercollegiate Sports benefit is limited to $75,000).
2. Injuries incurred while student is enrolled in and participating in the University of Illinois aviation program.
3. Physician's visits due to allergies (but not allergy testing or allergy medication).

Benefits will be paid up to the Maximum Benefits for each service specified below. Covered Medical Expenses include:

Inpatient	
Hospital Expense Benefit, maximum Daily Room and Board Allowance shall not exceed the average semi-private room rate charged by the Hospital in which confined.	After satisfying a $100 Deductible and paying the first $10,000 at 80% the balance of room and board charges and other Hospital expenses incurred, including Intensive Care will be paid at 100%.
Intensive Care	Paid under Hospital Expense Benefit
Routine Newborn Care, 48 hours vaginal / 96 hours cesearean Hospital Confinement expense maximum.	Paid as any other Sickness
Physiotherapy	Paid under Hospital Expense Benefit
Pre-Admission Testing, payable within 7 working days prior to admission.	Paid under Hospital Expense Benefit
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Assistant Surgeon	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)

Inpatient	
Anesthetist, professional services administered in connection with inpatient surgery.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Consultant Physicians Fees, when requested and approved by the attending Physician.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Physician's Visits, benefits are limited to one visit per day. Benefits do not apply when related to surgery. (The Physicians Visits benefit will pay for a specialist visit on the same day as a Physician's visit with a referral from the Physician. Physician's Visits while confined in an Intensive Care unit will be paid at 50% of Usual and Customary Charges.)	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Psychotherapy, benefits are limited to one visit per day. $20,000 Maximum Lifetime Benefit for Inpatient and Outpatient Charges.	Paid as any other Sickness
Outpatient	
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Assistant Surgeon	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Anesthetist, professional services administered in connection with outpatient surgery.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Medical Emergency, use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. $50 Deductible per visit in addition to the $150 policy Deductible.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Physician's Visits, benefits are limited to one visit per day. Benefit will pay for a specialist visit on the same day as a Physician visit with a referral from the Physician.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Physiotherapy, benefits are limited to one visit per day. ($900 maximum Per Policy Year.)	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)

Outpatient	
X-Rays and Laboratory	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Prescription Drugs	No Benefits
Chemotherapy and Radiation Therapy	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Psychotherapy, benefits are limited to one visit per day. Includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder. $20,000 Maximum Lifetime for Inpatient and Outpatient charges.	50% of expenses incurred / $35 Per Day Maximum / 45 days Maximum
Other	
Ambulance, includes benefit for air ambulance.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered. Benefit is for accidental Injury only. Benefits are allowed for splints casts crutches and braces only.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Dental, benefits paid on Injury to Sound, Natural Teeth and the removal of partially bony or completely bony impacted wisdom teeth and TMJ.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Alcoholism	Paid as any other Sickness
Drug Abuse	Paid under Psychotherapy
Maternity	Paid as any other Sickness
Routine Well-Baby Care, routine well baby benefits apply to the first birthday. Includes the following immunizations: measles, mumps and rubella, MMR, rotavirus and Pneumococcal.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Elective Abortion	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness
CAT Scan/MRI, (Cat scans $800 maximum, MRI $1,200 maximum and Nuclear Imaging $782 maximum.)	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Congenital Conditions, $10,000 maximum.	Paid as any other Sickness

Schedule of Medical Expense Benefits
Graduate Plan
Plan 2 (2011-1351-2)

Maximum Lifetime Benefit $1,000,000 (Lifetime)
Outpatient Deductible $150 (Per Insured Person) (Per Policy Year)

The policy provides benefits for of Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Lifetime Benefit of $1,000,000.

UnitedHealthcare Options PPO Network of Hospitals and health care providers have agreed to accept special reimbursement rates for treatment rendered to Insureds; therefore, use of UnitedHealthcare Options PPO Network of Hospitals and health care providers may result in lower out of pocket expenses.

NOTE: The maximum out-of-pocket for any single Insured Person is $1,800. The maximum out-of-pocket for any insured family unit is $3,600.

NOTE: This plan covers:

1. Injuries incurred while participating in intercollegiate, club and intramural sports. (Intercollegiate Sports benefit is limited to $75,000).
2. Injuries incurred while student is enrolled in and participating in the University of Illinois aviation program.
3. Physician's visits due to allergies (but not allergy testing or allergy medication).

Benefits will be paid up to the Maximum Benefit for each service specified below. Covered Medical Expenses include:

Inpatient	
Hospital Expense Benefit, maximum Daily Room and Board Allowance shall not exceed the average semi-private room rate charged by the Hospital in which confined.	After satisfying a $100 Deductible and paying the first $5,000 at 80% the balance of room and board charges and other Hospital expenses incurred, including Intensive Care will be paid at 100% of Usual & Customary Charges.
Intensive Care	Paid under Hospital Expense Benefit
Routine Newborn Care, 48 hours vaginal / 96 hours cesarean Hospital Confinement expense maximum.	Paid as any other Sickness
Physiotherapy	Paid under Hospital Expense Benefit
Pre-Admission Testing, payable within 7 working days prior to admission.	Paid under Hospital Expense Benefit
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)

Inpatient	
Assistant Surgeon	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Anesthetist, professional services administered in connection with inpatient surgery.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Physician's Visits, benefits are limited to one visit per day. Benefits do not apply when related to surgery. In the event of confinement in an Intensive Care Unit, Physician's charges for visits while so confined shall be payable at 50% of the Physicians Usual and Customary Charges or 50% of the actual charge, whichever is less. Physician and/or Specialist visit maximum of one visit each per day of Hospital Confinement.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Psychotherapy, benefits are limited to one visit per day.	Paid as any other Sickness / $100,000 Maximum Lifetime for Inpatient and Outpatient charges.
Outpatient	
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Assistant Surgeon	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Anesthetist, professional services administered in connection with outpatient surgery.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Medical Emergency, use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. $50 Per Emergency Room Visit; in addition to the policy Outpatient Deductible.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Physician's Visits, (Physicians Visits benefit will pay for a specialist visit on the same day as a Physician visit with a referral from the Physician.)	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Physiotherapy, benefits are limited to one visit per day. ($1,500 maximum Per Policy Year.)	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)

Outpatient	
X-Rays and Laboratory	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Prescription Drugs	No Benefits
Chemotherapy and Radiation Therapy	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Psychotherapy, benefits are limited to one visit per day. Includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder. $100,000 Maximum Lifetime for Inpatient and Outpatient charges.	50% of expenses incurred / $50 Per day Maximum / 52 days Maximum
Other	
Ambulance, includes benefit for air ambulance.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Consultant Physician Fees, when requested and approved by the attending Physician.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.. Benefits are allowed for splints, casts, crutches and braces required in the treatment of accidental injury only.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Dental, benefits paid on Injury to Sound, Natural Teeth and the removal of partially bony or completely bony impacted wisdom teeth and TMJ.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Alcoholism	Paid as any other Sickness
Drug Abuse	Paid under Psychotherapy
Maternity	Paid as any other Sickness
Routine Well-Baby Care, routine well baby benefits apply to the first birthday. Includes the following immunizations: measles, mumps and rubella, (MMR), rotavirus and Pneumococcal.	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Elective Abortion	Paid as any other Sickness

Other	
Complications of Pregnancy	Paid as any other Sickness
CAT Scan/MRI	80% of Usual and Customary Charges, or 80% of the actual charges (whichever is less)
Congenital Conditions, $10,000 maximum.	Paid as any other Sickness

Medical Expense Benefits
Maximum Lifetime Benefit (Plan 2 - Graduate Students Only)

The aggregate amount payable by the Company for incurred Covered Medical Expenses for Injury or Sickness will never exceed an amount determined by subtracting from the sum of $1,000,000 the following: (i) all amounts paid under this policy for any Injury or Sickness; (ii) all amounts paid to or in respect of an Insured for any Injury or Sickness under any other policy issued to the Policyholder by this Company, regardless of the policy period of such other policy; (iii) all amounts paid to an Insured under a student health or accident policy issued by another insurer (including the prior insurer) to the Policyholder, regardless of the policy period of such other policy.

The Maximum Benefit for all benefit coverage afforded under this policy is $1,000,000. Covered Medical Expenses shall not include amounts paid by the Insured for coinsurance.

Benefit Provisions

Maximum Amount Payable Undergraduate Plan 1 (2011-1351-1)

If an Insured Person incurs expenses as defined herein, the total payment by the Plan for each Injury or Sickness, shall in no event exceed an aggregate Maximum Amount Payable of $200,000 per Injury or Sickness of a Covered Person. The total payment with respect to Psychiatric (Psychotherapy) and Substance Abuse shall in no event exceed a Maximum Amount Payable of $20,000 per individual lifetime of a Covered Person. Amounts paid to the insured under this policy and under all prior year's policies will be considered payments accrued under the Maximum Lifetime Benefit.

Maximum Amount Payable Graduate Plan 2 (2011-1351-2)

If an Insured Person incurs expenses as defined herein, the total payment by the Plan, shall in no event exceed an aggregate Maximum Amount Payable of $1,000,000 maximum lifetime of an Insured Person. The total payment with respect to psychiatric and substance abuse shall in no event exceed a Maximum Amount Payable of $100,000 per individual lifetime of an Insured Person. Amounts paid to the Insured under this policy and under all prior year's policies will be considered payments accrued under the Maximum Lifetime Benefit.

Hospital Expense Benefits

If an Insured Person while insured hereunder becomes confined in a Hospital as a resident patient because of Accidental Bodily Injury, Sickness, or pregnancy, the Plan will pay such Hospital expenses incurred which are in excess of the "Deductible" when applicable, up to the applicable Maximum Benefit specified in the Schedule of Benefits, for:

(a) Daily Hospital Room and Board, subject to $100 Deductible up to the maximum specified in the Schedule of Benefits, and

(b) Hospital Expenses, including operating room, drugs, blood and blood plasma (including administration thereof), X-ray examinations, radiation treatments, laboratory tests, surgical dressings, and medical supplies while Hospital confined.

If the Insured person, other than newborn, is an inpatient in a health care facility on his/her Coverage Date, such person's Coverage Date will be the date of discharge.

Separate Hospital confinements are considered one period of confinement unless:

(1) The later confinement commences after a period of three consecutive months free from confinement, or

(2) The later confinement is due to causes entirely unrelated to the causes of the earlier confinement, or

(3) In the case of an Insured Student, the confinements are separated by the ability to return to classes on a full-time basis for a period of at least ten days.

Surgical Expense Benefits

If an Insured Person, while insured under these provisions, undergoes a surgical procedure which results from Sickness, Injury, or pregnancy, the Plan will pay 80% of the Actual Charge or 80% of the Usual and Customary Charge whichever is less, including the usual pre- and post-operative care.

If during a single surgical session two or more operations are performed in separate or same operative fields and through separate or same incisions, the limit of payment will be 80% of the Usual and Customary Charge for any one of the operations so performed, plus 50% of the amount specified for each lesser operation.

For concurrent care of multiple injuries to bones or joints not contiguous and not in the same hand or foot, the limit of payment will be 80% of the Usual and Customary Charge for any one of the procedures so performed, plus 50% of the amount specified for each lesser procedure.

Dental surgery benefits are for injury to Sound, Natural Teeth and the removal of both partial bony and complete bony impacted wisdom teeth.

Assistant Surgeon Expense Benefit

Expenses for an assistant surgeon associated with a surgical procedure shall be paid in the amount specified in the Schedule of Benefits, but not to exceed the actual amount charged.

Pre-Admission Testing / Miscellaneous Hospital Expense Benefit

Expenses for standard pre-admission tests associated with an inpatient or outpatient surgical procedure provided tests are performed within 7 days of admission shall be deemed eligible miscellaneous hospital expenses.

Hospital expenses other than those for actual surgery, which are associated with an outpatient surgical procedure and which are incurred on the same day as the procedure at the same operative session are eligible for miscellaneous expense benefits.

Anesthesia Expense Benefits

If an Insured Person, while insured hereunder, undergoes a surgical or obstetrical procedure for which a Surgical Expense Benefit is payable, in connection therewith, incurs charges made by a licensed Physician for personally administering anesthesia who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia service, the Plan will pay 80% of the Usual and Customary charges or 80% of the actual charge, whichever is less.

Physician's Hospital Expense Benefits

If an Insured Person, while insured hereunder, requires a Physician's visit for treatment of Sickness or Injury while confined in a Hospital as a resident patient, the Plan will pay the amount specified in the Schedule of Benefits for medical visits while so confined.

No benefit shall be payable for Hospital visits expenses which are incurred as a result of a surgical procedure, for postoperative care when service is rendered by the surgeon.

Consultant Physicians Fees

If the attending Physician requires the medical consult of a specialist, such expense shall be payable in the amount specified in the Schedule of Benefits, but not to exceed the actual amount charged.

Maternity Expense Benefits

If a female Insured Student or Insured Dependent, while insured hereunder, incurs Hospital, obstetrical or anesthesia expenses associated with normal childbirth, caesarean section, miscarriage or surgical abortion, the Plan will pay the benefits the same as any other sickness as described under:

1) Physician's visits;
2) Diagnostic services;
3) Obstetrical/surgical procedures;
4) Hospital room and board expenses;
5) Hospital miscellaneous expenses; and
6) Routine well-baby care while Hospital Confined.

as specified in the Schedule of Benefits, but not to exceed the actual amount charged. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/Alpha-Fetoprotein Screening and Chromosome Testing.

Newborn Infant Expense Benefits

Newborn Infant means any child born of an Insured while that person is insured under this Policy. Newborn Infants will be covered under the Policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

Coverage beyond first 31 days of birth

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to us; and 2) pay the required additional premium for the continued coverage. All coverage concerning the newborn will terminate at the end of the first 31 days after the child's birth, if additional insurance is not purchased through this office within 31 days after the child is born.

Ambulance Expense Benefits

If an Insured Person, while insured hereunder, incurs such expense in connection with professional ambulance service for transportation to the Hospital by reason of an Injury or Sickness, the Plan will pay such expenses not to exceed the applicable amount as stated in the Schedule of Benefits.

Outpatient Diagnostic Procedure Expense Benefits (Undergraduate Plan 1)

If an Insured Person, while insured hereunder, requires an Outpatient Diagnostic procedure in connection with the treatment of an Injury or Sickness, the Plan will pay such expense limited to those scheduled services listed:

CT Scans the lesser of 80% of Usual and Customary Charges or 80% of the actual charge, but not more than $800;

MRI the lesser of 80% of Usual and Customary Charges or 80% of the actual charge, but not more than $1,200; and

Nuclear imaging the lesser of 80% of Usual and Customary Charges or 80% of the actual charge, but not more than $782.

Outpatient Diagnostic Procedure Expense Benefits (Graduate Plan 2)

If an Insured Person, while insured hereunder, requires an Outpatient Diagnostic procedure in connection with the treatment of an Injury or Sickness, the Plan will pay such expense limited to those scheduled services listed:

CT Scans the lesser of 80% of Usual and Customary Charges.

Psychiatric (Psychotherapy) and Drug Abuse Expense Benefits

Lifetime Benefit payable for the following services: $20,000 **(Undergraduate Plan 1)** $100,000 **(Graduate Plan 2)**.

Inpatient Services

If an Insured Person, while insured hereunder, is confined as an inpatient in a Hospital, (see Hospital definition) benefits will be paid the same as any other Sickness as shown in the Schedule of Benefits.

Outpatient Services

If an Insured Person, while insured hereunder, incurs expenses for Outpatient services rendered by a Physician or licensed clinical psychologist, the Plan will pay such expenses not to exceed the applicable amount shown in the Schedule of Benefits.

"Psychotherapy" means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

Intercollegiate Sports Benefit

Insured student athletes who are members of and are participating in intercollegiate sports sponsored by the Policyholder are covered for sports Injury.

Benefits will be paid under the Schedule of Benefits for intercollegiate sports Injury up to $75,000 for each Injury.

No benefits will be paid for loss or expense caused by, or resulting from:

1. Infections, except pyogenic infections caused wholly by a covered Injury;
2. Cysts, blisters, or boils;
3. Overexertion; heat exhaustion; fainting;
4. Hernia, all types, regardless of how caused; and
5. Artificial aids such as crutches, braces, appliances, and artificial limbs.

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury independent of disease and bodily infirmity 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 regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

Payment of Benefits

Benefits for loss of life of an Insured Student shall be made in the following order: 1) spouse, if living; 2) children, if living; 3) parents, if living; or 4) estate of such Insured Student. All other benefits payable hereunder shall be paid to the Insured Student.

This benefit takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

Exception: exclusions shall not apply to loss sustained by an Insured Person holding a student pilot certificate or pilot license while riding in, boarding, or alighting from any aircraft owned by the University of Illinois, provided such person is registered in a course of formal flight instruction sponsored by the University of Illinois.

Excess Provision

Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance.

Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance.

However, this Excess Provision will not be applied to the first $100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

Conversion Privilege

The Company offers a Conversion Plan upon the Insured's Termination Date. The Conversion Plan does not provide the same premium rate and benefits as this Policy. A Conversion Plan enrollment form and a description of benefits provided may be obtained from the Student Insurance Office. It is the responsibility of the student to request this information.

Mammography Benefit

Benefits will be paid the same as any other Sickness for screening by Low-dose Mammography for the presence of occult breast cancer according to the following guidelines:

1. A baseline mammogram for women thirty-five to thirty-nine years of age.
2. An annual mammogram for women forty years of age or older.
3. A mammogram at the age and intervals considered medically necessary by the woman's Physician for women under 40 years of age and having a family history of breast cancer or other risk factors.

"Low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than one rad per breast for 2 views of an average size breast.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Bone Mass Measurement/Osteoporosis

Benefits will be paid the same as any other Sickness for medically necessary bone mass measurement and for the diagnosis and treatment of osteoporosis.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Colorectal Cancer Test Benefit

Benefits will be paid the same as any other Sickness for a colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every 3 years for Insureds who are at least 50 years old or for Insureds who are at least 30 years old and who may be classified as high risk for colorectal cancer because the Insured or a first degree family member of the Insured has a history of colorectal cancer.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Mastectomy, Prosthetic Device & Reconstructive Surgery

Benefits will be paid the same as any other Sickness for the surgical procedure known as a mastectomy and the prosthetic device or reconstructive surgery incident to the mastectomy.

Benefits for breast reconstruction in connection with a mastectomy shall include:

1. Reconstruction of the breast upon which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment for physical complications at all stages of mastectomy, including lymphedemas.

When a mastectomy is performed and there is no evidence of malignancy, benefits will be limited to the cost of the prosthesis or reconstructive surgery to within 2 years after the date of the mastectomy. Benefits for the prosthetic device and reconstructive surgery shall be subject to the Deductible and coinsurance provisions applied to the mastectomy and all other terms and conditions applicable to other benefits under the policy.

"Mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed Physician.

Cervical Cancer Screening Test Benefit

Benefits will be paid the same as any other Sickness for an annual cervical smear or pap smear test and annual Surveillance Tests for ovarian cancer for female Insureds who are At Risk for Ovarian Cancer.

Surveillance Tests for ovarian cancer means annual screening using (1) CA-125 serum tumor marker testing, (2) transvaginal ultrasound, and (3) pelvic examination.

At Risk for Ovarian Cancer means: 1) having a family history (i) with one or more first-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, or (iii) of nonpolyposis colorectal cancer, or 2) testing positive for BRCA1 or BRCA2 mutations.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Contraceptive Drug Coverage Benefit

Benefits will be paid the same as any other Sickness for all Outpatient Contraceptive Services and all outpatient contraceptive drugs and devices approved by the United States Food and Drug Administration.

Outpatient Contraceptive Service means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy. Please be aware that this policy does not cover Outpatient Prescription Drugs for Injury or Sickness and this would include prescription contraceptives.

Diabetes Benefit

Benefits will be paid as specified below for an Insured Person with type 1, type 2 or gestational diabetes mellitus for Medically Necessary equipment, supplies, foot care exams, and Diabetes Self-Management Training including medical nutrition therapy when prescribed by a Physician.

Diabetes Self-Management Training: Diabetes Self-Management Training means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes Self-Management Training includes the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy, which shall have the same meaning ascribed to “medical nutrition care” in the Dietetic and Nutrition Services Practices Act.

Diabetes Self-Management Training, including nutrition education, may be provided as a part of an office visit, group setting or home visit as authorized by the Insured’s Physician.

Benefits are limited to the following:

1) Up to 3 medically necessary visits to a Physician with expertise in diabetes management upon initial diagnosis of diabetes by the Insured’s Physician.
2) Up to 2 medically necessary visits to a Physician with expertise in diabetes management upon a determination by an Insured’s Physician that a significant change in the Insured’s symptoms or medical condition has occurred. A “significant change” means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

Foot Care Exams: Benefits will be paid the same as any other Sickness for regular foot care exams by a Physician.

Durable Medical Equipment: If the policy provides benefits for Durable Medical Equipment, benefits will be paid the same as any other Sickness for the following medically necessary equipment when prescribed by the Insured’s Physician: 1) blood glucose monitors; 2) blood glucose monitors for the legally blind; 3) cartridges for the legally blind; and 4) lancets and lancing devices.

Pharmaceuticals And Supplies: If the policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Sickness for the following medically necessary pharmaceuticals and supplies when prescribed by the Insured’s Physician: 1) insulin; 2) syringes and needles; 3) test strips for glucose monitors; 4) FDA approved oral agents used to control blood sugar; & 5) Glucagons emergency kits.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Prostate Cancer Screening Benefit

Benefits will be paid the same as any other Sickness for an annual digital rectal examination and a prostate-specific antigen test upon the recommendation of a licensed Physician for asymptomatic men age 50 and over; African-American men age 40 and over; and men age 40 and over with a family history of prostate cancer.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Dental Care Services Benefit

Benefits will be paid the same as any other Sickness for anesthetics and associated Hospital or ambulatory facility charges provided in conjunction with dental care for:

1. a child age 6 or under;
2. an individual with a medical condition that requires hospitalization or general anesthesia for dental care; or
3. an individual who is disabled.

This benefit does not cover charges for the dental care itself, only the charges for the anesthesia and associated Hospital or ambulatory facility charges.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Definitions

Covered Medical Expenses means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

Deductible means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefit.

Dependent means a Named Insured's spouse (husband or wife) or Domestic Partner and any unmarried child: (1) from birth to age 19 including an adopted child, a child who lives with the Insured from the time of the filing of a petition for adoption, a stepchild or recognized child who lives with the Insured in a parent-child relationship, or a child who lives with the Insured if such Insured is a court appointed guardian of the child; or (2) age 19 to 23 if enrolled as a full-time student in any accredited school, financially dependent upon the Insured. Dependent also includes any child under age 18 for which the Named Insured is under court order to provide medical coverage.

The Company may inquire of the Named Insured 2 months prior to attainment by a Dependent of the limiting age set forth in the policy, or at any reasonable time thereafter, whether such Dependent is in fact a disabled and dependent person and, in the absence of proof submitted within 60 days of such inquiry that such Dependent is a disabled and dependent person may terminate coverage of such person at or after attainment of the limiting age. In the absence of such inquiry, coverage of any disabled and dependent person shall continue through the term of such policy or any extension or renewal thereof.

A child, regardless of age, who becomes eligible to be assessed the U of I student insurance fee is not eligible to be covered as a dependent child.

Domestic Partner means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

Elective Surgery and Elective Treatment means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

Graduate Student, (as defined herein) means any graduate student of the University of Illinois who is enrolled, in attendance, and assessed all fees (except correspondence, extra-mural, visiting students or students registered in absentia).

Hospital means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises or in facilities available to the Hospital on a pre-arranged basis; and 6) is not primarily a clinic, nursing, rest or convalescent home.

Injury means bodily injury which is: 1) the direct cause of loss, independent of disease cause of loss, independent of disease or bodily infirmity; 2) a source of loss; 3) treated by a Physician within 30 days after the date of accident; and 4) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

Insured Person means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term "Insured" also means Insured Person.

Intensive Care means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

Medical Necessity means those services or supplies provided or prescribed by a Hospital or Physician which are:

1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury;
3) In accordance with the standards of good medical practice;
4) Not primarily for the convenience of the Insured, or the Insured's Physician; and,
5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

Named Insured means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

Pre-Existing Condition means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under the policy.

Sickness means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

Sound, Natural Teeth means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

Undergraduate Student, (as defined herein) means an undergraduate student of the University of Illinois who is enrolled, in attendance, and assessed all fees (except correspondence, extra-mural, visiting students or students registered in absentia).

Usual and Customary Charges means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions and Limitations

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

1. Acupuncture; allergy, including allergy testing; except as specifically provided in the policy;
2. Addiction, such as: nicotine addiction;
3. Learning disabilities;
4. Biofeedback;
5. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
6. Dental treatment, except as specifically provided in the Schedule of Benefits;
7. Elective Surgery or Elective Treatment;
8. Eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses; except when due to a disease process;
9. Foot care including: care of corns, bunions (except capsular or bone surgery), calluses;
10. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
11. Hirsutism; alopecia;
12. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
13. Injury caused by or resulting from or any services rendered because of or resulting from intoxication, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician; Intoxication is defined and determined by the laws of the state where the loss or cause of the loss was incurred.
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
15. Injury sustained while (a) participating in any interscholastic or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
16. Organ transplants, only those considered experimental are excluded;
17. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
18. Pre-existing Conditions as follows: in the event of a lapse in coverage or if coverage is waived and the individual purchases coverage under this policy during open enrollment, benefits will not be payable for Pre-existing Conditions for 12 consecutive months from the Insured's Effective Date of the new coverage under this policy;
19. Prescription Drugs dispensed or purchased while not Hospital Confined;
20. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
21. Routine Newborn Infant Care, well baby and nursery related Physician Charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
22. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;

23. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia;
24. Sleep disorders;
25. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
26. Supplies, except as specifically provided in the policy;
27. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
28. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
29. 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); and
30. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the permanent number on the ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

Scholastic Emergency Services: Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you and your insured spouse or domestic partner and minor child(ren) are eligible for Scholastic Emergency Services (SES). The requirements to receive these services are as follows:

International Students, insured spouse or domestic partner and insured minor child(ren): You are eligible to receive SES worldwide, except in your home country.

Domestic Students, insured spouse or domestic partner and insured minor child(ren): You are eligible for SES when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

SES includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, Inc.; any services not arranged by SES, Inc. will not be considered for payment.

Key Services include:

* Medical Consultation, Evaluation and Referrals
* Foreign Hospital Admission Guarantee
* Emergency Medical Evacuation
* Medically Supervised Repatriation
* Emergency Counseling Services
* Lost Luggage or Document Assistance
* Care for Minor Children Left Unattended Due to a Medical Incident
* Prescription Assistance
* Critical Care Monitoring
* Return of Mortal Remains
* Transportation to Join Patient
* Interpreter and Legal Referrals

Please visit your school's insurance coverage page at www.uhcsr.com for the SES Global Emergency Assistance Services brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States
(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

When calling the SES Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached.

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at www.uhcsr.com for additional information, including limitations and exclusions pertaining to the SES program.

General Plan Provisions

(These provisions are extracts from the Policy and apply to all insurance provided hereunder.)

Proof of Loss: Written proof of loss must be furnished to the Administrator at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

Payment of Claims: All or a portion of any indemnities provided by this Policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the Estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

Right of Reimbursement: If an Insured Person incurs expenses for Sickness or an Injury that occurred due to the negligence of a third party:

A) The Company has the right to reimbursement for all benefits paid by the Company from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured Person, Insured Person's parents, if the Insured Person is a minor, or Insured Person's legal representative as a result of that Sickness or Injury.

B) The Company is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Company for that Sickness or Injury

The Company has the right to reimbursement out of all funds the Insured Person, the Insured Person's parents, if the Insured Person is a minor, or the Insured Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

Legal Actions: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

Subrogation: Whenever this policy has paid benefits because of Sickness or an Injury to any Insured Person resulting from a third party's wrongful act or negligence, to the extent of such payment the Company shall reserve the right to assume the legal claim any Insured Person may have against that third party. This means that the Company may choose to take legal action against the negligent third party or their representatives and to recover from them the amount of claim benefits paid to the Insured Person for loss caused by the third party.

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SRID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

How to File Claims

A Student Insurance Claim Form must be completed annually. Forms can be completed online at our website www.si.illinois.edu or in our office.

Claims submitted by a Hospital must include a UB-92 form, an itemized statement of charges, including diagnosis.

Claims submitted by Physicians or other Medical Providers must include an itemized statement of charges, including diagnosis and all necessary codes.

All claims and required information must be submitted within one year of the date of service. Claims submitted after this date will not be eligible for benefits.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

For all Customer Service Inquiries contact:

Benefits Center - Student Insurance

506 South Wright Street, Room 100A

Urbana, Illinois 61801

(217) 333-0165

Fax: (217) 244-9886

E-mail address: insure@illinois.edu

Submit claims to:

UnitedHealthcare StudentResources

P.O. Box 809025

Dallas, Texas 75380-9025

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

The Health Care benefits described in this Brochure are underwritten for the University of Illinois by UnitedHealthcare Insurance Company and are based on Policy numbers **2011-1351-1 and 2011-1351-2.**