2012 - 2013
STUDENT INJURY AND SICKNESS INSURANCE PLAN

DESIGNED ESPECIALLY FOR GRADUATE TEACHING ASSISTANTS, GRADUATE RESEARCH ASSISTANTS AND GRADUATE ASSISTANTS ATTENDING:

Emporia State University
www.uhcsr.com/emporia

Kansas State University
www.uhcsr.com/k-state

Pittsburg State University
www.uhcsr.com/pittstate

University of Kansas
www.uhcsr.com/ku

University of Kansas Medical Center
www.uhcsr.com/kumc

Wichita State University
www.uhcsr.com/wichita

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.

UnitedHealthcare®
A UnitedHealth Group Company

12-BR-KS (118-3) 15-200118-3

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $100,000 for each Injury or Sickness that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-888-344-6104. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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Dear Student:

The Kansas Board of Regents (KBOR) in cooperation with the Regents Institutions of the State of Kansas, is pleased to offer to students and their dependents, a Blanket Injury and Sickness Insurance Plan underwritten by UnitedHealthcare Insurance Company and administered by UnitedHealthcare **Student**Resources.

Preferred Providers are members of the UnitedHealthcare Choice Plus Network. Additionally, for Pittsburg State University students, Mount Carmel Regional Medical Center is a Preferred Provider. These providers offer you superior access to a choice of qualified physicians, hospitals, and Preferred Provider network programs nationwide, while reducing the costs of your medical care with rates that are usually much lower than normal charges.

If you choose to seek treatment from an out-of-network provider, your benefits may be reduced.

Participation in this program is voluntary; however, we encourage you to carefully read the entire booklet to familiarize yourself with the available plan and benefits. Any questions about this plan should be directed to UnitedHealthcare **Student**Resources at 1-888-344-6104.

Student Health Center Information

This student health insurance plan is designed to coordinate with the services provided by the Student Health Center for students. Please check with your university's health center to determine whether spouses and/or dependent children are eligible to use the health center. The Student Health Center acts as a Gatekeeper for the plan and can evaluate your condition and provide treatment or a referral to a specialist as necessary. The Student Health Center is staffed with professionals that are familiar with the unique needs of students and can meet most of the health care needs the student may have. Check to see what hours and what services are available. The treatment provided by the Student Health Center is of high quality and is cost efficient for the patient.

When possible, it is recommended that you go to your Student Health Center when seeking treatment.

Emporia State University	www.emporia.edu/shc/	620-341-5223
Kansas State University	www.k-state.edu/lafene/	785-532-6544
Pittsburg State University	www.pittstate.edu/health/	620-235-4452
University of Kansas	www.studenthealth.ku.edu/	785-864-9500
University of Kansas Medical Center	www.kumc.edu/studentcenter/health.html	913-588-1941
Wichita State University	www.wichita.edu/shs	316-978-3620

Eligibility and How To Enroll

Each student who is a graduate teaching assistant, graduate research assistant or graduate assistant holding a 50% appointment is eligible for an employer contribution toward the cost of coverage. The reduced premium rates for the graduate teaching, graduate research assistants and graduate assistants program reflects the cost to the student after the employer contribution has been made. **To enroll go to www.uhcsr.com/kbor, select your university, click on the link under the heading "GRA/GTA/GA Enrollment Instructions and follow the instructions, as applications are now submitted online. For WSU students only: Complete the enrollment form and return it to the designated university contact. Your premium will be added to your student fee bill.** After August 1, brochures can be picked up at your Graduate Office, Human Resources Department or Student Health Center. If you do not hold a qualifying 50% GTA, GRA and/or GA appointment, you may be eligible for other student insurance coverage. Information is available at the student health centers or online at www.uhcsr.com/kbor.

Please read the following carefully to understand your opportunities with respect to enrollment.

On or before August 1, brochures can be picked up at your Graduate Office, Human Resources Department or Student Health Center. Eligibility is verified by the university once the first step of the online application process is completed. **For WSU students only:** Eligibility will be verified prior to applications and premiums being sent to UnitedHealthcare **Student**Resources.

All applications with correct premium payments received within 31 days of the period effective date will be effective the first day of the period. For example: Applications and premium payments received August 1-August 31, 2012, will receive an effective date of August 1, 2012. For all other applications received outside of the open enrollment period, coverage will be effective the date the correct premium is received by the Company or representative of the Company or the effective date of the coverage period, whichever is later.

Eligibility to participate as a GTA/GRA/GA is determined by the university. Many unique situations may occur throughout the academic year related to enrollment as well as movement between the GTA/GRA/GA plan and the voluntary student health insurance program. See the designated contact for your university for assistance.

GTA/GRA/GA's with F-1 and J-1 visas are required to participate in this plan unless proof of other insurance is provided. The premium for coverage will be added to the tuition billing of those International Students attending Kansas State University, University of Kansas and Pittsburg State who do not show proof of comparable coverage and are required to participate in this plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements that the Student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the Policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse and children under 26 years of age. Dependent Eligibility expires concurrently with that of the Insured student. Dependent coverage must be applied for by completing the online application (and for WSU students, filling out the enrollment card) and by paying the required premium. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student. Dependents that are not in the country at the time the student enrolls will be eligible to be enrolled in coverage within 30 days of entering the country.

Effective and Termination Dates

The Master Policy on file at the Kansas Board of Regents (KBOR) becomes effective at 12:01 a.m., August 1, 2012. Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company or its authorized representative, whichever is later, except as specified in the How to Enroll section. The Master Policy terminates at 11:59 p.m., July 31, 2013. Coverage terminates on that date or at the end of the period through which premium is paid whichever is earlier. Dependent coverage will not be effective prior to that of the insured student or extend beyond that of the insured student. The Master Policy can be viewed at www.kansasregents.org.

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. It is the student's responsibility to make timely renewal payments to avoid a lapse in coverage.

Refunds of premiums are allowed only upon entry into the armed forces. This is a non-renewable One Year Term Policy.

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 30 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.

Pre-Admission Notification

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide the notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Pre-Admission Notification is not a guarantee or Pre-Certification that specific benefits will be paid. All provisions and exclusions in this policy apply to any services received, regardless of Medical Necessity.

Schedule of Medical Expense Benefits

Injury and Sickness

Maximum Benefit: $100,000 Paid As Specified Below
(For Each Injury or Sickness)

Deductible Preferred Provider: $300 (Per Insured Person) (Per Policy Year)
Deductible Out-of-Network: $600 (Per Insured Person) (Per Policy Year)

Coinsurance Preferred Provider: 80% except as noted below
Coinsurance Out-of-Network: 60% except as noted below

Out-of-Pocket Maximum Preferred Providers:
$10,000 (Per Insured Person, Per Policy Year)

Out-of-Pocket Maximum Out of Network:
$20,000 (Per Insured Person, Per Policy Year)

The Preferred Providers in your local school area are members of the UnitedHealthcare Choice Plus. Additionally, for Pittsburg State University students, Mount Carmel Regional Medical Center is a Preferred Provider.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% up to the policy Maximum Benefit subject to any benefit maximums that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. The policy Deductible, Copays and per service Deductibles and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays and per service Deductibles.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $100,000 for each Injury or Sickness.

Usual and Customary Charges will be calculated based on the 80th percentile of FAIR Health, Inc.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. A $5 Copay will apply for all lab procedures and X-rays (except as noted below) at the Student Health Center.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Covered Medical Expenses include:

PA = Preferred Allowance	U&C = Usual & Customary Charges	
INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Room and Board Expense, daily semi-private room rate when confined as an Inpatient and general nursing care provided by the Hospital.	80% of PA	60% of U&C
Intensive Care	Paid under Room and Board Expense	
Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, including pap smears, x-ray examinations, including mammograms, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of U&C
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
Physiotherapy	Paid under Hospital Miscellaneous Expenses	
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 50% of all subsequent procedures.	80% of PA	60% of U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits are limited to one visit per day and do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
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 50% of all subsequent procedures.	80% of PA	60% of U&C
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 PA	60% of U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
Physician's Visits, benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of PA $25 Copay per visit	60% of U&C
Physiotherapy, benefits are limited to one visit per day. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of PA	60% of U&C
Medical Emergency Expenses, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. *(The Copay/per visit Deductible are in addition to the Policy Deductible.) (Copay/per visit Deductible will be waived if admitted to the Hospital.)*	80% of PA / $100 Copay per visit	80% of U&C / $100 Deductible per visit
Diagnostic X-ray Services, including mammograms. *(Benefits are payable at 100% for a chest x-ray as a result of a positive TB test required by the school, not subject to the $5 Copay/Deductible or Pre-existing Condition.)*	80% of PA	60% of U&C
Radiation Therapy	80% of PA	60% of U&C
Chemotherapy	80% of PA	60% of U&C
Laboratory Services, including pap smears.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-Rays and Lab Procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy. *(Benefits provided for a TB test required by the school are payable at 100%. This benefit is not subject to the $5 Copay/Deductible or Pre-existing Condition.)*	80% of PA	60% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C
Prescription Drugs Prescriptions must be filled at the SHC or a UnitedHealthcare Network Pharmacy (UHPS) participating pharmacy. (The Deductible does not apply.)	Student Health Center: $5 Copay per prescription for generic prescriptions/ 30% Copay for brand name prescriptions UnitedHealthcare Network Pharmacy (UHPS): $15 Copay per prescription for Tier 1/ 30% Copay for Tier 2 / up to a 31-day supply per prescription	No Benefits
OTHER		
Ambulance Services	80% of PA	60% of U&C
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. *($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum Per Policy Year are not included in the $100,000 Maximum Benefit.)*	80% of PA	60% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	80% of PA	60% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *($100 maximum per tooth) (Benefits are not subject to the $100,000 Maximum Benefit.)*	80% of U&C	60% of U&C

OTHER	Preferred Providers	Out-of-Network Providers
Mental Illness Treatment, services received on an Inpatient and outpatient basis. Benefits are limited to one visit per day. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. Benefits are limited to one visit per day. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	
Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	No Benefits	
Preventive Care Services, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.	100% of PA	No Benefits

OTHER	Preferred Providers	Out-of-Network Providers
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy. See Benefits for Breast Reconstruction following a Mastectomy.	Paid as any other Sickness	
Diabetes Services, in connection with the treatment of diabetes for Medically Necessary: 1) outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals; and 2) Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.	Paid as any other Sickness	
Repatriation/Medical Evacuation	Benefits provided by Scholastic Emergency Services	

Prescription Drug Benefit

Student Health Center

You will also be able to purchase drugs prescribed for a Covered Injury or Sickness at the Student Health Center. There is a $5 copay for each generic drug and a 30% Copay for each brand name drug. Please see the Schedule of Benefits for additional information.

UnitedHealthcare Network Pharmacy

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and Copayments and/or Coinsurance that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable Copayments and/or Coinsurance. Your Copayment/Coinsurance is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 1-877-417-7345 for the most up-to-date tier status.

$15 Copay per prescription order or refill for a Tier 1 Prescription drug up to a 31 day supply.

30% Copay per prescription order or refill for a Tier 2 Prescription drug up to a 31 day supply.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use the Student Health Center or network pharmacy, you will be responsible for paying the full cost for the prescription. If you do not present the card, you will need to pay the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com and log in to your online account or call 877-417-7345.

NOTE: Insureds will not be able to pay only their Copays at participating UnitedHealthcare Network Pharmacies until they are assigned an ID number and receive their permanent ID Card. If you need to purchase a prescription prior to receiving your ID number, visit www.uhcsr.com or call 1-877-417-7345 for information on submitting a prescription drug claim for reimbursement.

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven, except for drugs for the treatment of cancer that are a recognized treatment in one of the standard reference compendia or in substantially accepted peer reviewed medical literature.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compound drugs that contain at least one ingredient that requires a Prescription order or Refill are assigned to Tier 2.
4. Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a prescription order or refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

Definitions

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service at 1-877-417-7345.

Preferred Providers

"**Preferred Providers**" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in your local school area are members of the UnitedHealthcare Choice Plus Network. Additionally, for Pittsburg State University students, Mount Carmel Regional Medical Center is a Preferred Provider.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a provider is participating at the time services are required by calling the Company at 1-888-344-6104 and/or by asking the provider when making an appointment for services.

"Preferred Allowance" means the amount a Preferred Provider and In-Network Provider will accept as payment in full for Covered Medical Expenses.

"Out of Network" providers have not agreed to any prearranged fee schedules. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

"Network Area" means the 40 mile radius around the local school campus the Named Insured is attending.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-888-344-6104 for information about Preferred Hospitals.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Choice Plus and Mount Carmel Regional Medical Center will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Maternity Testing

This policy does not cover all routine, preventive, or screening examinations or testing. The following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met.

Initial screening at first visit:

- Pregnancy test: urine human chorionic gonatropin (HCG)
- Asymptomatic bacteriuria: urine culture
- Blood type and Rh antibody
- Rubella
- Pregnancy-associated plasma protein-A (PAPPA) **(first trimester only)**
- Free beta human chorionic gonadotrophin (hCG) **(first trimester only)**
- Hepatitis B: HBsAg
- Pap smear
- Gonorrhea: Gc culture
- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

- Ultrasound (anatomy scan)
- Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a

Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS)

Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-888-344-6104.

Continuation Benefits

Insureds may pay for continuing coverage for a maximum of up to 3 months due to loss of appointment. The Insured has a right to choose to continue benefits as long as the school maintains a plan with our Company. The Insured must exercise this right within 60 days of termination by calling UnitedHealthcare **Student**Resources at 1-888-344-6104 or see the designated contact for your university. Upon request a Certificate of prior creditable coverage will be provided when an employee or their dependent ceases to be covered under this policy.

Coordination of Benefits

The Policy contains a Coordination of Benefits provision. If you, or any of your Eligible Dependents, are covered under any other eligible medical, surgical or hospital plan of insurance, we will coordinate benefit payments with the other plan. Benefit payments by both plans will never exceed 100% of the Allowable Expenses incurred for covered services and supplies. You are required to furnish to UnitedHealthcare **Student**Resources the Explanation of Benefit statement from your other carrier in order for claims to be payable under the Policy.

Benefits for Osteoporosis

Benefits will be paid the same as any other Sickness for Insureds with a condition or medical history for which bone mass measurement is medically necessary. Benefits include services for the diagnosis, treatment and management of osteoporosis when provided by a Physician. Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Cytologic Screening and Mammography

Benefits will be paid the same as any other Sickness for mammograms, cytologic screening, or (pap) smears when performed at the direction of a Physician.

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

Benefits for Breast Reconstruction Following a Mastectomy

Benefits will be paid the same as any other Sickness for Insureds who elect breast reconstruction in connection with a mastectomy. Benefits include:

(1) reconstruction of the breast on which the mastectomy was performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications in all stages of mastectomy, including lymphedemas.

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

Benefits for General Anesthesia and Medical Care Facility for Dental Care

Benefits will be paid the same as any other Sickness for the administration of general anesthesia and medical care facility charges for dental care provided to the following Insureds:

1. A Dependent child five years of age and under; or
2. An Insured who is severely disabled; or
3. An Insured that has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

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

Benefits for Childhood Immunizations

Benefits will be paid the same as any other Sickness for immunizations for children from birth to 72 months of age. Immunizations shall consist of at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B (Hib); and three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella and such other vaccines and dosages as may be prescribed by the secretary of health and environment.

Benefits shall not be subject to any Deductible, Copayment or Coinsurance requirements.

Benefits for Cancer Clinical Trials

Benefits will be paid the same as any other Sickness for Routine Patient Care Costs for an Insured who has been diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer and the treating Physician determines that participation in the clinical trial has a meaningful potential to benefit the Insured.

“Routine patient care costs” means those costs associated with the provision of health care services, including, items, devices, treatments, diagnostics, and services that would typically be covered in the policy for patients not participating in a clinical trial.

“Routine patient care costs” shall not include the costs associated with the provision of any of the following:

(1) Drugs or devices that have not been approved by the federal food and drug administration and that are associated with the clinical trial;

(2) Services other than health care services, including travel, housing, companion

expense, other non-clinical expenses that an Insured could require as a result of the treatment being provided for purposes of the clinical trial;

(3) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;

(4) Health care services, except for the fact that they are being provided in a clinical trial, or otherwise specifically excluded from coverage under this policy; or

(5) Health care services customarily provided by the research sponsors of a trial free of charge for any in the trial.

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

Definitions

ADOPTED CHILD means the adopted child or foster child placed with an Insured while that person is covered under this policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted or foster child not more than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured's residence.

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 date of placement: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

COPAYMENT OR COPAY means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

CUSTODIAL CARE means services that are any of the following:

1) Non-health related services, such as assistance in activities.
2) Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3) Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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 as specified in the Schedule of Benefits.

DEPENDENT means the spouse (husband or wife) of the Named Insured and their dependent, children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap.
2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

ELECTIVE AND EXPERIMENTAL SURGERY OR 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.

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; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental Illness or Substance Use Disorder.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is all of the following:

1) directly and independently caused by specific accidental contact with another body or object.
2) unrelated to any pathological, functional, or structural disorder.
3) a source of loss.
4) treated by a Physician within 30 days after the date of accident.
5) 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. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. 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.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital by reason of an Injury or Sickness for which benefits are payable 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.
6) Other facilities which do not meet the standards for intensive care.

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 any of the following:

1) Death.
2) Placement of the Insured's health in jeopardy.
3) Serious impairment of bodily functions.
4) Serious dysfunction of any body organ or part.
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "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.

MEDICAL NECESSITY means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

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) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means that both:

1) The Insured requires acute care as a bed patient.
2) The Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

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.

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.

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, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medial Expenses will be paid at 100% for the remainder of the Policy Year according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

1) Deductibles.
2) Copays.
3) Expenses that are not Covered Medical Expenses.

PHYSICIAN means a health care provider who is: 1) duly licensed under the Kansas healing arts act; 2) acting within his/her lawful scope of practice; and 3) not 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.

PHYSIOTHERAPY means any form of the following short-term rehabilitation therapies: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POLICY YEAR means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

PRE-EXISTING CONDITION means: 1) the existence of symptoms within the 6 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 6 months immediately prior to the Insured's Effective Date under the policy. The Pre-existing exclusion is not applicable to pregnancy.

PRESCRIPTION DRUGS mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

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.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or 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. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. 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. The data used to determine the usual and customary charges is updated at least every six months.

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. Automobile Excess- No payment will be made for Hospital, medical or other health services resulting from accidental bodily Injury arising out of a motor vehicle accident to the extent that benefits are payable under any medical expense payment provision of any automobile insurance policy, including such benefits mandated by law;
2. Congenital conditions, except as specifically provided for Newborn or adopted Infants; circumcision;
3. 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;
4. Custodial Care services and supplies related to custodial care such as 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 also are not covered for domiciliary or Custodial Care;
5. Acne; acupuncture; alopecia; biofeedback-type services; corns, calluses and bunions; deviated nasal septum; gynecomastia; hirsutism; learning disabilities; nasal and sinus surgery; nicotine addiction; except as specifically provided in the policy; nonmalignant warts, moles and lesions for cosmetic reasons; obesity and any condition resulting therefrom; patient controlled analgesia (PCA); skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing thereof; temporomandibular joint dysfunction; Elective and Experimental Surgery or Treatment;
6. Elective abortion;
7. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
8. Injury sustained while (a) participating in any intercollegiate, 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;
9. Hearing examinations or hearing aids; or other treatment for hearing defects and problems except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
10. Immunizations services and supplies related to 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;
11. Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenics, 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;
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
13. Organ transplants, including organ donation;
14. Pre-existing Conditions except for: 1) individuals who have been continuously insured for at least 9 months under any plan as defined under Creditable Prior Coverage if the previous coverage was continuous to a date not more than 63 days prior to the Insured's Effective Date under the Policy; or 2) individuals who have been continuously insured for at least 9 months under the school's student insurance policy; or 3) an Insured Person who is under age 19.

    "Creditable Prior Coverage" means any individual or group policy, contract or program provided by an HMO, Insurer, self-insured employer plan or any other entity that

arranges or provides medical, hospital or surgical coverage, not designed to supplement other private or governmental plans. It should include prior coverage under a group or individual sickness and accident policy, provided by a government plan (such as Medicaid and Medicare) COBRA, CHAMPUS, the Federal Employee Health Benefits Plan, Peace Corps Plans, the Indian Health Service, coverage provided through state high risk pools and other public plans.

Insured Persons who have been insured under a coverage as defined in Creditable Prior Coverage and have no gap in such coverage that exceeds 63 days immediately prior to enrollment in this plan will receive the applicable amount of credit for prior coverage. If an Insured Person has 9 months prior creditable coverage with no gap in coverage exceeding 63 days immediately prior to enrollment in this plan the pre-existing limitation is satisfied.

15. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
16. Prescription Drug services or supplies as follows:
    a) 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;
    b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for drugs for the treatment of cancer that are a recognized treatment in one of the standard reference compendia or in substantially accepted peer reviewed medical literature;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
17. 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. Examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery;
18. Routine Newborn Infant care, well-baby nursery and related Physician charges; except as specifically provided in the Policy;
19. Preventive care services; 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;
20. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
21. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;

22. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
23. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and
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).

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 number indicated on the permanent 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 and minor child(ren) are eligible for SES services. The requirements to receive these services are as follows:

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

Domestic Students, insured spouse and insured minor child(ren): You are eligible for SES services 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 services include Emergency Medical Evacuation and Return of Mortal Remains that meet the US Visa requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace or local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, any services not arranged by SES will not be considered for payment.

Key Services include:

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

Please log into your online account www.uhcsr.com for additional information on SES Global Emergency Assistance Services, including 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 SES's 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. 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 Provisions

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company 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.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

PAYMENT OF CLAIMS: All benefits are payable to the Insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parents, guardian, or other person actually supporting him. Subject to any written direction of the Insured, all or a portion of any benefits payable under this policy may be paid directly to the Hospital, Physician or person rendering the service or treatment. Any payment made by us in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

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 5 years after the time written proofs of loss are required to be furnished.

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 888-344-6104 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Appeal.

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact Claims Appeals at 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

After exhausting the Company's Internal Appeal process, the Insured Person, or the Insured Person's Authorized Representative, has the right to request an External Independent Review when the service or treatment in question:

1. Is a Covered Medical Expense under the Policy; and
2. Is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level or care, or effectiveness.

Standard External Review

A Standard External Review request must be submitted in writing within 120 days of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited External Review

An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and

    a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and

    b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function;

or

2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and

    a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

    b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance departmentat the following address:

Kansas Insurance Department
Consumer Assistance
420 S.W. 9th Street
Topeka, KS 66612
Consumer Assistance Hotline: 800-432-2484
Main Number: 785-296-3071
Email: Commissioner@ksinsurance.org

Questions Regarding Appeal Rights

Contact Customer Service 888-344-6104 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state department of insurance may be able to assist you at:

Kansas Insurance Department
Consumer Assistance
420 S.W. 9th Street
Topeka, KS 66612
Consumer Assistance Hotline: 800-432-2484
Main Number: 785-296-3071
Email: Commissioner@ksinsurance.org
Online: www.ksinsurance.org

Notice to Student:

Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By enrolling online or, for WSU students completing the enrollment form, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll; 2) Rates are not pro-rated other than as listed; 3) He/She meets the eligibility requirements for this coverage as described in this brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

Period Dates and Rates

2012-200118-3

	Fall	Spring	Summer
A. Student	$ 131.00	$ 131.00	$ 50.00
B. Student and Spouse	$227300	$227300	$ 911.00
C. Student and All Children	$1977.00	$1977.00	$ 791.00
D. Student, Spouse & All Children	$4119.00	$4119.00	$ 1652.00

Fall 08-01-2012 through 12-31-2012 Spring 01-01-2013 through 05-31-2013
Summer 06-01-2013 through 07-31-2013

Payment Instructions: (all except WSU students)

Students must enroll online at www.uhcsr.com/kbor. Select your university, click Enroll Now and follow the instructions.

Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

Payment Instructions: Wichita State University Only:

Complete the enrollment form and return it to the designated university contact. Your premium will be added to your student fee bill.

Emporia State University
Jennifer Stout,
Human Resources
1200 Commercial - Box 44
Emporia, KS 66801
phone (620) 341-5379
fax (620) 341-6014
email: jstout@emporia.edu

Pittsburg State University
Debbie Amershek
Human Resources Dept.
204 Russ Hall,
701 S. Broadway
Pittsburg, KS 66762
phone (620) 235-4187
fax (620) 235-6002
email: damershe@pittstate.edu

University of Kansas
Mary Karten
Benefits/HR
Carruth O'Leary Hall
1246 W. Campus Rd,
Room 152
Lawrence, KS 66045-7505
phone (785) 864-7346
fax (785) 864-5200
email: mkarten@ku.edu

Kansas State University
Stephanie Harvey
Human Resources Dept.
103 Edwards Hall
Manhattan, KS 66506-4801
phone (785)532-6277
fax (785)532-6095
email: Benadmin@ksu.edu

University of Kansas Medical Center
3901 Rainbow Blvd.
3013 Student Center
Kansas City, KS 66160
phone (913) 588-6211
fax (913) 588-4697
email:
studenthealthinsurance@kumc.edu

***Wichita State University**
Constance Noble
Graduate School
1845 Fairmont
Wichita, KS 67260-0004
phone (316) 978-6241
fax (316) 978-3253

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, correspondence and coverage information via My Account at www.uhcsr.com. Insureds can also print a temporary ID card, request a replacement ID card and locate network providers from My Account. You may also access the most popular My Account features from your smartphone at our mobile site: my.uhcsr.com.

If you don't already have an online account, simply select the "Create an Account" link from the home page at uhcsr.com. Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from uhcsr.com to access your account information.

Claim Procedure

In the event of Injury or Sickness, the student 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, social security number and name of the college 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.

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-888-344-6104
customerservice@uhcsr.com
claims@uhcsr.com

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Please keep this Certificate as a general summary of the insurance. The Master Policy is on file at the Kansas Board of Regents (KBOR) at www.kansasregents.org and contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control payment of benefits.

This Certificate is based on Policy # 2012-200118-3 **v9**