2013-2014

**PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS**

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

ILLINOIS
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

Undergraduate Plan

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

UnitedHealthcare®
A UnitedHealth Group Company

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 $500,000 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 1-888-224-4883. 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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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 1-888-224-4883 or visiting us at: www.uhcsr.com/illinois.

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 applicable tuition and fees. Coverage under the Plan is worldwide. Plan benefits are explained in the following pages. **Plan 1, Policy number 2013-1351-1, is applicable to undergraduate students and their Dependents only.**

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

Student	$ 254.00
Spouse of student*	$ 994.00
Child or all children of student*	$ 460.00

*(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.

NOTE: The Student and Child or all children of student amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

2013-2014 Important Dates & Deadlines*

*Deadlines are the dates by which exemptions, 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.

	Fall Semester	Spring Semester	Summer Session
Semester Coverage Periods:	08/21/2013 - 01/17/2014	01/18/2014 - 05/16/2014	05/17/2014 - 08/20/2014
Enrollment/ Change Period:	08/19/2013 - 09/25/2013	01/18/2014 - 02/27/2014	05/17/2014 - 06/16/2014

Dependents acquired through marriage, civil union 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.

Eligibility

Students of the University of Illinois who are enrolled, in attendance, and assessed all applicable fees are eligible for the Student Health Insurance Plan. The fee is automatically assessed along with other tuition and fees. Plan 1, Policy number 2013-1351-1, is applicable to undergraduate students and their Dependents only.

Undergraduate students (as defined herein) of the University of Illinois who are enrolled, in attendance, and assessed all applicable 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.

Students must actively attend classes for at least the first 31days 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 Eligibility or 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.

Accident coverage for Intercollegiate Sports injuries is provided under a separate policy number 2013-1351-8.

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, civil union partner, 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.

Dependent coverage is available for dependents of students who enroll in the Student Health Insurance Plan. Rates and enrollment information for dependents can be found on-line at www.uhcsr.com/myaccount.

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, birth or adoption 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 has benefits equivalent to or better than 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 may be submitted by completing the on-line Waiver request at https://studentcenter.uhcsr.com/Illinois. For deadline information, refer to the 2013-2014 Important Dates and Deadlines section on page 1. Exemptions need to be requested at the start of each policy year.

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 by bringing in documentation to the Student Insurance Office in Urbana. 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, page 15 - the Pre-Existing Condition exclusion will not be applied to an Insured Person who is under age 19.). Student must be registered and eligible to be assessed fee. Proof of loss should be taken to the Student Health Insurance office.

Extension of Coverage

Graduating Students

Graduating students may elect to continue coverage for themselves and for Insured Dependents for up to the 90 day continuation period. Please refer to the continuation privilege section found on page 11 of this brochure for further details

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 country. 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

Injury and Sickness

Maximum Benefit $500,000 Paid as Specified Below (For each Injury or Sickness)

Outpatient Deductible: $150 (Per Insured Person) (Per Policy Year)

Coinsurance: 80% except as noted below

The Policy provides benefits for Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $500,000 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. All benefits payable for Covered Medical Expenses are subject to the Coinsurance noted above and the maximum benefits for each service specified below.

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.

Covered Medical Expenses include:

Inpatient	**U&C = Usual and Customary Charges**
Hospital Expense, daily semi-private room rate when confined as an Inpatient; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory test, x-ray examinations, 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.	After satisfying a $100 per admission Deductible and paying the first $10,000 Per Injury or Sickness 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
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

Inpatient	
Physiotherapy	Paid under Hospital Expense
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 U&C
Assistant Surgeon	80% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of U&C
Registered Nurse's Services	No Benefits
Physician's Visits, non-surgical services when confined as an Inpatient.	80% of U&C
Pre-Admission Testing, payable within 7 working days prior to admission.	Paid under Hospital Expense
Outpatient	
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 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 U&C
Assistant Surgeon	80% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of U&C

Outpatient	
Physician's Visits, Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	80% of U&C
Physiotherapy, 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 resulting from Injury or Sickness. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% 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. *($50 Deductible per Emergency Room visit in addition to the $150 Policy Outpatient Deductible.)*	80% of U&C / $50 Deductible per visit
Diagnostic X-ray Services	80% of U&C
Radiation Therapy	80% of U&C
Laboratory Services	80% of U&C
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.	80% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of U&C
Chemotherapy	80% of U&C
Prescription Drugs	No Benefits

Other	
Ambulance Services, *(Includes benefits for air ambulance.)*	80% 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.	80% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	80% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth and TMJ only. *(Benefits are not subject to the $500,000 Maximum Benefit)* *(Benefits for TMJ are subject to a separate $500,000 maximum and are not included in the $500,000 Maximum Benefit)*	80% of U&C
Dental Treatment, benefits paid for removal of impacted wisdom teeth only.	80% of U&C
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
Elective Abortion, *(Elective Abortion benefits are not subject to the $500,000 Maximum Benefit.)*	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness
Congenital Conditions	Paid as any other Sickness
Mental Illness Treatment, services received on an Inpatient basis while confined to a Hospital and on an outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness
Hospital Outpatient Facilty or Clinic	80% of U&C

Other	
Substance Use Disorder Treatment, services received on an Inpatient basis while confined to a Hospital and on an outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.	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. (Benefits are provided for diabetic test strips and lancets at 80% of Usual and Customary Charges.)	Paid as any other Sickness
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 or Coinsurance will be applied to Preventive Care Services.)	100% of Billed Charges

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 1-888-224-4883.

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 in addition to payment under the Medical Expense Benefits.

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.

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.

Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student Policy for at least one semester and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

Benefits for Dental Care Services

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

Copay/Copayment 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.

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 as specified in the Schedule of Benefits.

Dependent means a Named Insured's spouse (husband or wife), a party to a civil union established according to Illinois law, or Domestic Partner of the Named Insured and their dependent children. Dependent children include: 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. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

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.

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.

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, or an institution specializing in or primarily treating Mental Illness or Substance Use Disorder. The requirement for major surgery facilities does not apply to treatment or services for rehabilitation or mental illness rendered in a hospital.

Injury means bodily injury which is all of the following:

1) the direct cause of loss, independent of disease cause of loss, independent of disease or bodily infirmity.
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. 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 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) Not primarily for the convenience of the Insured, or the Insured's Physician.
5) 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.

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 first manifests itself 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.

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

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.

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 any of the following:

1. Acupuncture;
2. Addiction, such as: nicotine addiction, except as specifically provided in the policy;
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 covered Injury or disease process;
9. Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery);
10. Hearing examinations; 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;
11. Hirsutism; alopecia;
12. Injury caused by or resulting from the use of intoxicants, 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;
13. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
14. Injury sustained while (a) participating in any interscholastic, intercollegiate 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;
15. Experimental organ transplants;
16. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
17. 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. This exclusion will not be applied to an Insured Person who is under age 19;

18. Prescription Drugs dispensed or purchased while not Hospital Confined, except as specifically provided in the policy;
19. 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; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
20. Routine Newborn Infant Care, well baby and nursery related Physician Charges except as specifically provided in the policy;
21. Routine physical examinations and routine testing; preventative testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
22. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia;
23. Sleep disorders;
24. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
25. Supplies, except as specifically provided in the policy;
26. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
27. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
28. 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
29. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

FrontierMEDEX: Global Emergency Services

If you are a student insured with this insurance plan, you and your insured spouse Domestic Partner or Civil Union Partners and minor child(ren) are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

International Students, insured spouse, Domestic Partner or Civil Union Partners and insured minor child(ren): You are eligible to receive FrontierMEDEX services worldwide, except in your home country.

Domestic Students, insured spouse, Domestic Partner or Civil Union Partners and insured minor child(ren): You are eligible for FrontierMEDEX 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.

FrontierMEDEX 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 services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment.

Key Services include:

*Transfer of Insurance Information to Medical Providers
*Transfer of Medical Records
*Worldwide Medical and Dental Referrals
*Emergency Medical Evacuation
*Transportation to Join a Hospitalized Participant
*Replacement of Corrective Lenses and Medical Devices
*Monitoring of Treatment
*Medication, Vaccine and Blood Transfers
*Dispatch of Doctors/Specialists
*Facilitation of Hospital Admission Payments
*Transportation After Stabilization
*Emergency Travel Arrangements
*Continuous Updates to Family and Home Physician
*Replacement of Lost or Stolen

*Hotel Arrangements for Convalescence
*Return of Dependent Children
*Legal Referrals
*Message Transmittals
Travel Documents
*Repatriation of Mortal Remains
*Transfer of Funds
*Translation Services

Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(800) 527-0218 Toll-free within the United States

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

When calling the FrontierMEDEX 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 FrontierMEDEX ID Number as listed on your Medical ID Card;
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.

FrontierMEDEX 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 FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in MyAccount at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

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 1-888-224-4883 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: 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: Claims Appeals, 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 4 months 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.

Standard Experimental or Investigational External Review

An Insured Person, or an Insured Person's Authorized Representative, may submit a request for an Experimental or Investigational External Review when the denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational.

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational External Review

An Insured Person, or an Insured Person's Authorized Representative, may submit an oral request for an Expedited Experimental or Investigational External Review 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 denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective is not initiated promptly; 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 is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly.

Where to Send External Review Requests

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

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
877-850-4740 toll free phone
217-557-8495 fax

Questions Regarding Appeal Rights

Contact Customer Service T 1-888-224-4883 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:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
877-850-4740 toll free phone
217-557-8495 fax
Insurance.Illinois.gov/ExternalReview

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to ***My Account*** at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "create My Account Now" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare **Student**Resources' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account has been enhanced to include *Message Center* - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

ID Cards

One way we are becoming greener is to no longer automatically mail out ***ID Cards***. Instead, we will send an email notification when the digital ID card is available to be downloaded from ***My Account***. An Insured student may also use ***My Account*** to request delivery of a permanent ID card through the mail. ID Cards may also be accessed via our mobile site at my.uhcsr.com.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to ***My Account*** as described above and select *UnitedHealth Allies Plan* to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed 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.

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) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number (your insurance company ID number) and name of the University under which the student is insured.
2) 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.

The Plan is Underwritten by

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-888-224-4883

customerservice@uhcsr.com

claims@uhcsr.com

General Inquiries

Student Insurance Office

506 South Wright Street

Henry Administration Building, Room 100A

Urbana, IL 61801

1-217-333-0165

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 Number:

2013-1351-1

ILLINOIS

UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2013-1351-1

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

NOC # 1 (08/13/13)

1. Maternity Testing paragraph needs to be updated with the direct TFN # of 1-888-224-4883.

2. Under 2013-2014 Important Dates & Deadlines*Deadlines are the dates by which exemptions, extensions, limited enrollment reinstatements or...(PLEASE REMOVE THE WORD EXTENSIONS)

3. Under "Purchase of Insurance for spouse, Domestic Partner and/or children:"Rates and enrollment information for dependents can be found on-line at www.uhcsr.com/illinois. (2nd paragraph link is incorrect. (Please replace link with www.uhcsr.com/Myaccount)

NOC # 3 (11/11/13)

Added “Hospital Outpatient Facilty or Clinic” benefits for 80% of U&C