2013-2014

PLEASE NOTE:

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

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

WILLIAM & MARY®

Notice: This Plan is subject to regulation by the Virginia Department of Health and the Bureau of Insurance.

Important:

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

The Plan is Underwritten by
UNITEDHEALTHCARE INSURANCE COMPANY

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 $1,000,000 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 1-800-767-0700. 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 us toll-free at 800-767-0700 or visiting us at www.uhcsr.com/wm.

Eligibility

All International students are required to purchase this insurance Plan and the premium for coverage is added to their tuition billing.

All full-time domestic undergraduate students and domestic graduate students are automatically enrolled in this insurance Plan at registration and premium for coverage is added to their tuition billing, unless proof of comparable coverage is provided.

All Visiting Faculty Scholars and Graduate Research and Graduate Teaching Assistants who are approved by the College to pursue academic work are required to purchase this insurance Plan, unless proof of comparable coverage is furnished.

All other domestic full-time undergraduate or graduate students are eligible to enroll in this insurance 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 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.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse or Domestic Partner and dependent children (including children that the Insured must provide coverage due to court order) under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2013. The individual student's 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. The Master Policy terminates at 11:59 p.m., July 31, 2014. 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.

Coverage expires as follows:

Annual	08-01-13 to 07-31-14
Fall	08-01-13 to 01-15-14
Spring/Summer	01-16-14 to 07-31-14
Summer	05-28-14 to 07-31-14

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the coverage expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

Refunds of premiums are allowed only upon entry into the armed forces. The Policy 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 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.

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 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: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

Student Health Center (SHC) Referral Required

(Students Only)

The student must use the resources of the Student Health Center (SHC) first where treatment will be administered, or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage.

A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A SHC referral for outside care is not necessary only under any of the following conditions:

1) Medical Emergency. The student must return to SHC for necessary follow-up care.
2) When the Student Health Center is closed.
3) When service is rendered at another facility during break or vacation periods.
4) Medical care received when the student is more than 10 miles from campus.
5) Medical care obtained when a student is no longer able to use the SHC due to a change in student status.
6) Maternity, obstetrical and gynecological care.
7) Mental Illness treatment and Substance Use Disorder treatment.

Dependents are not eligible to use the SHC and therefore, are exempt from the above limitations and requirements.

Schedule of Medical Expense Benefits

Injury and Sickness

Maximum Benefit: Up to $1,000,000 Paid As Specified Below (For each Injury or Sickness)

Deductible: $200 (Per Insured Person, Per Policy Year)

Coinsurance: Preferred Provider: 80% except as noted below

Coinsurance: Out-of-Network: 50% except as noted below

The Preferred Provider for this plan UnitedHealthcare Options PPO.

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.

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 $1,000,000 for each Injury or Sickness.

Student Health Center Benefits: Benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Prescription Drugs are covered after $5 Copay per prescription for generic / $15 Copay per prescription for brand, up to a 31-day supply per prescription. Benefits for laboratory services will be payable after a $10 Copayment.

The SHC referral requirement is waived for routine vision benefits.

NOTE: Out-of-country claims will be paid at 80% of Usual and Customary Charges.

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. *($250 Copay/Deductible (Per Insured Person, Per Policy Year) in addition to the Policy Deductible.)*	80% of PA	50% of U&C
Intensive Care	80% of PA	50% of U&C

INPATIENT	Preferred Providers	Out-of-Network Providers
Hospital Miscellaneous Expense, such as the cost of the operating room, laboratory tests, 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.	80% of PA	50% 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	80% of PA	50% of U&C
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	50% of U&C
Assistant Surgeon	No Benefits	
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	80% of U&C
Registered Nurse's Services, private duty nursing care.	80% of PA	50% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient.	80% of PA	50% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	50% of U&C
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 PA	50% 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	50% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Assistant Surgeon	No Benefits	
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	80% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to Physiotherapy. The Copay/per visit Deductible is in lieu of the Policy Deductible. No Copay/per visit Deductible at the Student Health Center.	100% of PA / $30 Copay per visit	70% of U&C / $30 Deductible per visit
Physiotherapy, see exclusion 20 for additional limitations. 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. See also Benefits for Early Intervention Services	80% of PA	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. (The Copay/ per visit Deductible is in addition to the Policy Deductible.)	100% of PA / $75 Copay per visit	100% of U&C / $75 Deductible per visit
Diagnostic X-ray Services	80% of PA	50% of U&C
Radiation Therapy	80% of PA	50% of U&C
Chemotherapy	80% of PA	50% of U&C
Laboratory Services	80% of PA	50% 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 PA	50% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	50% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Prescription Drugs, (Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.)	UnitedHealthcare Pharmacy (UHCP) $15 Copay per prescription for Tier 1 $30 Copay per prescription for Tier 2 $50 Copay per prescription for Tier 3 up to a 31-day supply per prescription	No Benefits
OTHER		
Ambulance Services	80% of PA	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 PA	80% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	Paid under Physician's Visits	
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *($500 maximum for each Injury) (Benefits are not subject to the $1,000,000 Maximum Benefit.)*	80% of U&C	80% of U&C
Dental Examinations, *(One dental examination Per Policy Year.) (Dental Examination benefits are not subject to the $1,000,000 Maximum Benefit.)*	80% of U&C	80% of U&C
Vision, *($500 maximum Per Policy Year.) (Limited to one eye examination and eyeglasses Per Policy Year.) (Vision benefits are not subject to the $1,000,000 Maximum Benefit.)*	80% of PA	50% 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	
Complications of Pregnancy	Paid as any other Sickness	

OTHER	Preferred Providers	Out-of-Network Providers
Elective Abortion	No Benefits	
Mental Illness Treatment, services received on an Inpatient and outpatient basis. See Benefits for Biologically Based Mental Illness and Benefits for Mental Illness and Substance Abuse.	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. See Benefits for Biologically Based Mental Illness and Benefits for Mental Illness and Substance Abuse.	Paid as any other Sickness	
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy. See Benefits for Reconstructive Breast Surgery Following Mastectomy.	Paid as any other Sickness	
Home Health Care, services received from a licensed home health agency that are ordered by a Physician, provided or supervised by a Registered Nurse in the Insured Person's home, and pursuant to a home health plan. *(60 visits maximum Per Policy Year.)*	80% of PA	50% of U&C
Hospice Care, See Benefits for Hospice Care.	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. See also Benefits for Diabetes.	Paid as any other Sickness	
Sleep Apnea, *(Sleep Apnea benefits are not subject to the $1,000,000 Maximum Benefit.)*	Paid as any other Sickness	

OTHER	Preferred Providers	Out-of-Network Providers
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

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments 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. Your Copayment 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/wm or call 1-855-828-7716 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.
$50 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Mail order Prescription Drugs are available at 2.5 times the retail Copay up to a 90 day supply.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription. However, if a non-Network pharmacy has entered into an agreement with us that it agrees to accept the same terms and conditions applicable to Network Pharmacies, including reimbursement at the rate applicable to the Network Pharmacies, including applicable copayment, as payment in full, you may receive benefits on the same basis and at the same copayment as you would from a Network Pharmacy.

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/wm and log in to your online account or call 1-855-828-7716.

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.
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. Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3.
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

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

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/wm or call Customer Service at 1-855-828-7716.

Preferred Provider Information

"**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 the local school area are:

UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

"**Preferred Allowance**" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"**Out-of-Network**" providers have not agreed to any prearranged fee schedules. Insureds 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 10 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 Options PPO United Behavioral Health (UBH) facilities. Call (800) 767-0700 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 Options PPO 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 1-800-767-0700.

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes 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	$ 1,000
Two or More Members	$ 1,000
One Member	$ 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.

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 group insurance. This Excess Provision will not be applied to any claim against or settlement with a third person responsible for such personal Injury.

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 group 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 3 consecutive months 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.

Application must be made and premium must be paid directly to UnitedHealthcare **Student**Resources and be received within 31 days after the expiration date of your student coverage. For further information on the Continuation privilege, please contact UnitedHealthcare **Student**Resources at 1-800-767-0700.

Mandated Benefits

Benefits for Mammography

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

1. One screening Mammogram to persons age thirty-five through thirty-nine.
2. One Mammogram biennially to persons age forty through forty-nine.
3. One Mammogram annually to persons age fifty and over.

"Mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast. The equipment used to perform the mammogram must meet the radiation protection regulations standards set forth by the Virginia Department of Health.

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

Benefits for Reconstructive Breast Surgery Following Mastectomy

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery. The reimbursement for Reconstructive Breast Surgery will be determined according to the same formula by which charges are developed for other medical and surgical procedures.

"Mastectomy" means the surgical removal of all or part of the breast.

"Reconstructive breast surgery" means surgery performed (1) coincident with or following a Mastectomy or (2) following a Mastectomy to reestablish symmetry between the two breasts and while the Insured is covered under the policy. Reconstructive breast surgery shall also include coverage for prostheses, determined as necessary in consultation with the attending Physician and Insured, and physical complications of Mastectomy, including medically necessary treatment of lymphedemas.

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

Benefits for Inpatient Coverage Following Mastectomy

Benefits will be paid the same as any other Sickness for a minimum of 48 hours of inpatient care following a radical or modified radical mastectomy and a minimum of 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where the attending Physician in consultation with the patient determines that a shorter period of Hospital stay is appropriate.

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

Benefits for Pregnancy from Rape or Incest

Benefits will be paid as for any other Injury for pregnancy resulting from an act of rape or incest which was reported to the police within 7 days, or 180 days if under 13 years of age, following the incident.

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

Benefits for Pap Smears

Benefits will be paid the same as any other Sickness for an annual pap smear performed by any FDA approved gynecologic cytology screening technologies.

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

Benefits for Prostate Cancer Screening

Benefits will be paid the same as any other Sickness (1) for Insureds age fifty and over and (2) for Insureds age forty and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

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

Benefits for Colorectal Cancer Screening

Benefits will be paid the same as any other Sickness for colorectal cancer screening. Coverage shall include an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or, in appropriate circumstances, radiologic imaging shall be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

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

Benefits for Hysterectomy

Benefits will be paid the same as any other Sickness for a minimum of 23 hours Hospital stay for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. Nothing in this section shall be construed as requiring the total hours referenced when the attending Physician in consultation with the patient determines that a shorter period of Hospital stay is appropriate.

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

Benefits for Biologically Based Mental Illness

Benefits will be paid the same as any other Sickness for Biologically Based Mental Illness.

"Biologically based mental illness" means any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the Insured's functioning.

The following diagnoses are defined as Biologically Based Mental Illness as they apply to adults and children:

1. schizophrenia;
2. schizoaffective disorder;
3. bipolar disorder;
4. major depressive disorder;
5. panic disorder;
6. obsessive-compulsive disorder;
7. attention deficit hyperactivity disorder;
8. autism; or
9. drug and alcohol addiction.

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

Benefits for Mental Illness and Substance Abuse

Benefits will be paid the same as any other Sickness for inpatient, outpatient and partial hospitalization for mental illness and substance abuse services as follows:

1) Treatment for an adult as an inpatient at a Hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility.
2) Treatment for a child or adolescent as an inpatient at a Hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility.
3) Inpatient benefit may be converted when medically necessary at the option of the person or the parent, as defined in Virginia Statute 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage.

Benefits will be paid the same as any other Sickness for outpatient mental illness and substance abuse services for outpatient treatment of an adult, child or adolescent. Medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness. If all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any Deductible required by the policy, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy.

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

Benefits for Diabetes

Benefits will be paid for diabetes equipment and supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

As provided in the benefit, diabetes equipment and supplies shall not be considered Durable Medical Equipment under this policy.

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

Benefits for Clinical Trials for Treatment Studies on Cancer

Benefits will be paid the same as any other Sickness for Patient Costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the Insured for purposes of a clinical trial. Patient cost does not include (1) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (2) costs associated with managing the research associated with the clinical trial, or (3) the cost of the investigational drug or device.

Coverage for Patient Costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial. The treatment shall be provided by a clinical trial approved by:

(1) The National Cancer Institute (NCI);

(2) An NCI cooperative group or an NCI center;

(3) The Federal Food and Drug Administration (FDA) in the form of an investigational new drug application;

(4) The federal Department of Veterans Affairs; or

(5) An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

This benefit shall apply only if:

(1) There is no clearly superior, noninvestigational treatment alternative;

(2) The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and

(3) The Insured and the Physician or health care provider who provides services to the Insured conclude that the Insured's participation in the clinical trial would be appropriate, pursuant to procedures established by the Company, as disclosed in the policy and evidence of coverage.

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

Benefits for Prescription Drugs for Cancer Treatment and Treatment of a Covered Indication

Benefits will be paid for Prescription Drugs, whether on an inpatient or an outpatient basis, including all services that are a Medical Necessity associated with the administration of the drug, to treat cancer subject to the following provisions.

Benefits will not be denied for any drug approved by the United States Food and Drug Administration (FDA) for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia.

Benefits will not be denied for any drug prescribed to treat a covered indication so long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-reviewed Medical Literature.

"Standard reference compendia" means the American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network's Drugs & Biologics Compendium, or the Elsevier Gold Standard's Clinical Pharmacology.

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

This provision shall not be construed to do any of the following:

1. Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the specific type of cancer or indication for which the drug has been prescribed;
2. Require coverage for any experimental drug not otherwise approved for any indication by the FDA;
3. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA; or
4. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

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

Benefits for Prescriptions for Cancer Pain in Excess of Recommended Dosage

If benefits are provided under the policy for Prescription Drugs, benefits will be paid the same as any other Prescription Drug for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer pain. Benefits will not be denied on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia Statutes 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

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

Benefits for Hospice Care

Benefits will be paid the same as any other Sickness for Hospice Services.

"Hospice services" shall mean a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed under Article 7 (32.1-162.1 et seq.) of Chapter 5 of Title 32.1, and shall include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.

"Individuals with a terminal illness" shall mean individuals whose condition has been diagnosed as terminal by a licensed Physician, whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care.

"Palliative care" shall mean treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

Documentation requirements shall be no greater than those required for the same service under Medicare.

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

Benefits for Home Treatment of Hemophilia and Congenital Bleeding Disorders

Benefits will be paid the same as any other Sickness for the Home Treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Benefits include coverage for the purchase of Blood Products and Blood Infusion Equipment required for Home Treatment of routine bleeding episodes when the Home Treatment Program is under the supervision of the state-approved treatment center.

"Home treatment program" means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.

"State-approved hemophilia treatment center" means a Hospital or clinic which received federal or state Maternal and Child Health Bureau and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

"Blood infusion equipment' includes but is not limited to syringes and needles.

"Blood Product" includes but is not limited to, Factor VII, Factor VIII, Factor IX and cryoprecipitate.

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

Benefits for Treatment Involving Bones and Joints of the Head, Neck, Face or Jaw

Benefits will be paid for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw the same as for the diagnosis and treatment to any bone or joint of the skeletal structure. Such treatment must be required because of a Sickness or Injury which prevents normal function of the joint or bone and be deemed a Medical Necessity to attain functional capacity of the affected part.

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

Benefits for Early Intervention Services

Benefits will be paid the same as any other Sickness for medically necessary Early Intervention Services. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the Company to or on behalf of the Insured during the Insured's lifetime.

"Early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for Dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act. These services are designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

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

Benefits for Newborn Infant Hearing Screening

Benefits will be paid the same as any other Sickness for newborn infant hearing screenings and all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recommended by the National Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such benefits shall include any follow-up audiological examinations as recommended by a Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

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

Benefits for Routine and Necessary Childhood Immunizations

Benefits will be paid the same as any other Sickness for routine and necessary childhood immunizations for Dependent children from birth to thirty-six months. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other immunizations as may be prescribed by the Commissioner of Health.

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

Benefits for Telemedicine Services

Benefits will be paid the same as any other Sickness for medically necessary healthcare services provided through Telemedicine Services.

"Telemedicine services" means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. "Telemedicine services" do not include an audio-only telephone, electronic mail message, or facsimile transmission.

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

Benefits for General Anesthesia and Hospitalization for Dental Care

Benefits will be paid the same as any other Sickness for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to an Insured who is determined by a licensed dentist in consultation with the Insured's treating Physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care and (a) is under the age of five, or (b) is severely disabled, or (c) has a medical condition and requires admission to a Hospital or outpatient surgery facility for dental care treatment.

For purposes of this provision, a determination of Medical Necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the Insured requires the utilization of general anesthesia and the admission to a Hospital or outpatient surgery facility to safely provide the underlying dental care.

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

Benefits for Orally Administered Cancer Chemotherapy Drugs

Benefits will be paid for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the policy; provided that the Copayment, Coinsurance, and Deductibles are at least as favorable to an Insured Person as the Copays, Coinsurance or Deductibles that apply to intravenous or injected anticancer medications.

Benefits for Autism Spectrum Disorder

Benefits will be paid the same as any other Sickness for the Diagnosis of Autism Spectrum Disorder and the Treatment of Autism Spectrum Disorder in Insureds from age two through age six.

"Autism Spectrum Disorder" means any pervasive developmental disorder, including:

1. Autistic disorder.
2. Asperger's syndrome.
3. Rett syndrome.
4. Childhood disintegrative disorder.
5. Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Diagnosis of Autism Spectrum Disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.

"Treatment of Autism Spectrum Disorder" shall be identified in a treatment plan and includes the following medically necessary care prescribed or ordered by a Physician or Psychologist for an Insured diagnosed with Autism Spectrum Disorder:

1. Behavioral health treatment including professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning an individual.
2. Pharmacy care including medications prescribed by a Physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.
3. Psychiatric care and Psychological care such as direct or consultative services provided by a licensed Psychiatrist or Psychologist.

4. Therapeutic care provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or clinical social worker.
5. Applied behavior analysis when provided or supervised by a board certified behavior analyst licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

Except for Inpatient services, if an Insured is receiving treatment for an Autism Spectrum Disorder, the company shall have the right to review that treatment, but not more than once every 12 months, unless the Company and the Insured's Physician agree that more frequent review is necessary.

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

Benefits for Treatment of Morbid Obesity

Benefits will be paid the same as any other Sickness for the treatment of Morbid Obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for long-term reversal of Morbid Obesity. For the purpose of this endorsement, "morbid obesity" means (a) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (b) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (c) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

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

Definitions

ADOPTED OR NEWBORN CHILD means 1) a newly born child of the Insured from the moment of birth provided that person is insured under this policy; 2) a child adopted by the Insured provided the person adopting the child is insured under this policy on the date the adoption becomes effective; and 3) a child who has been placed for adoption with the Insured provided the person adopting the child is insured under the policy on the date the child is placed with the Insured. Such child will be covered under the policy for the first 31 days after: 1) birth of the newly born child; 2) the effective date of adoption of the child; and 3) the date of placement of the child for adoption, unless the placement is disrupted prior to final decree of adoption, and the child is removed from placement with the Insured. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity, nursery care; inpatient and outpatient dental, oral surgical, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia. 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 date of birth, adoption, or placement for adoption: 1) apply to the Company; 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 date of birth, adoption, or placement for adoption.

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.

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.

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) or Domestic Partner of the Named Insured and their dependent children and children that the Insured must provide coverage due to court order. 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 intellectual disability 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).

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 OR 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; and 6) is not primarily a clinic, nursing, rest or convalescent home.

For the treatment of Mental Illness and Substance Use Disorders, Hospital also means a licensed alcohol or drug rehabilitation facility, intermediate care facility, and mental health treatment facility. These facilities are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

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) 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. Mental Illness does not mean a Biologically Based Mental Illness as defined in the Benefits for Biologically Based Mental Illness. 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.

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.

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.

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. Substance Use Disorder does not mean a Biologically Based Mental Illness as defined in the Benefits for Biologically Based Mental Illness. 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.

Exclusions and Limitations

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

1. Acupuncture;
2. Assistant Surgeon Fees;
3. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or intellectual disability,
4. Circumcision;
5. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
6. 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;
7. Dental treatment; as specifically provided in the Schedule of Benefits
8. Elective Surgery or Elective Treatment;
9. Elective abortion;
10. 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 due to a covered Injury or disease process; or except as specifically provided in the policy;
11. Flat foot conditions; supportive devices for the foot; subluxations of the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);
12. Hearing examinations; hearing aids; or cochlear implants; 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;
13. Hirsutism; alopecia;
14. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury, except as specifically provided in the policy;
15. Injury caused by, contributed to, or resulting from the use of alcohol, 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;
16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
17. 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;
18. Lipectomy;
19. Organ Transplants;
20. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation; or when referred by the Student Health Center;
21. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

22. Prescription Drugs, 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; except as specifically provided in the Benefits for Home Treatment of Hemophilia and Congenital Bleeding Disorders;
    c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    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, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene;
    h. Growth hormones; or
    i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. 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;
24. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
25. 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;
26. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
27. 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;
28. Sleep disorders, except as specifically provided in the policy;
29. Supplies, except as specifically provided in the policy;
30. Surgical breast reduction, breast augmentation, breast implants, breast prosthetic devices; or gynecomastia, except as specifically provided in the policy;
31. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
32. 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
33. Weight management, weight reduction, nutrition programs, treatment for obesity, (except morbid 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 or Domestic Partner and minor child(ren) are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

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

Domestic Students, insured spouse or Domestic Partner 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
*Hotel Arrangements for Convalescence
*Return of Dependent Children
*Legal Referrals
*Message Transmittals
*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 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 FronterMEDEX 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.

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.

Notice of Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason, please contact the insurance company issuing this insurance at P. O. Box 809025, Dallas, Texas 75380-9025 or call toll-free at 1-800-767-0700. If you have been unable to contact or obtain satisfaction from the insurance company, you may contact:

Virginia State Corporation Commission
Life and Health Division
Bureau of Insurance
P. O. Box 1157
Richmond, Virginia 23218
Telephone: 1-804-371-9691
Toll-Free: 1-877-310-6560
TDD: 1-804-371-9206
Fax: 1-804-371-9944

Written correspondences is preferable so that a record of your inquiry is maintained.

General Provisions

The policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change the policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

A copy of any application of the Policyholder shall be attached to the Policy when issued. All statements made by the Policyholder shall be deemed representations and not warranties.

Indemnities payable under this policy for any loss will be paid within 60 days after receipt of due written proof of such loss.

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 the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

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.

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.

The validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. The Company reserves the right to contest the validity of the policy for up to two years from its date of issue. No statement made by any person insured under the policy relating to his insurability or the insurability of his insured Dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1) after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2) unless the statement is contained in a written instrument signed by him. This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

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 800-767-0700 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:

State Corporation Commission
Bureau of Insurance – External Review
P. O. Box 1157
Richmond, VA 23218
Phone: (877) 310-6560
Fax: (804) 371-9915
Email: externalreview @scc.virginia.gov

Questions Regarding Appeal Rights

Contact Customer Service at 800-767-0700 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 consumer assistance program may be able to assist you at:

Office of the Managed Care Ombudsman
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218
Phone: (804) 371-9032 (in Richmond)
(877) 310-6560 (outside Richmond)
Website: http://www.scc.virginia.gov/boi/omb/index.aspx
Email: ombudsman@scc.virginia .gov

Frequently Asked Questions

1) What are the changes from last years policy to the new 2013-2014 policy?

a) The Plan Maximum has been increased to $1,000,000 for each injury or Sickness.
b) Deleted Optional Major Medical benefits
c) Removed the limitation of "benefits are limited to one visit per day" for all providers.
c) Removed the Pre-existing exclusion and limitation
d) Cosmetic exclusion for "removal of wart, non-malignant moles and lesions" removed
e) Added benefit for one Dental Examination
f) Added benefit for Vision coverage

2) I need to see a doctor, do I need a referral and can I see any physician?

If you are within 10 miles from campus, you must see the Student Health Center for a referral prior to seeing your physician, unless any one of the following apply: 1) it is a medical emergency; 2) the Student Health Center is closed 3) you are on vacation; 4) you are no longer eligible to use the SHC due to a chane in student status; 5) Maternity, obstetrical and gynecological care; or 6) Treatment for Mental Illness or Substance Use Disorder. You may choose to see any health care provider with this plan. However, to receive the highest levels of coverage we encourage you to use a preferred provider under the UnitedHealthcare Options PPO.

3) What if there is no UnitedHealthcare Options PPO provider in my area, I am out of state or traveling abroad?

If a preferred provider is not available in the network area, benefits will be paid at the level of benefits shown as in-network benefits.

Out-of-country claims will be paid at 80% of Allowable Charges.

4) I gave my doctor the temporary ID card and they would not accept it. What should I do?

Have the health care provider call 1-800-767-0700 or the number on your I.D. Card for verification of coverage and benefits. This is an acceptable card and should not be refused by the health care provider. The provider may be telling you that they do not participate as a UnitedHealthcare Options PPO preferred provider, but this does not mean they will not see you as a patient or file the insurance for you.

5) What is the Deductible?

$200 Per Insured Person, Per Policy Year, an additional Inpatient Room and Board $250 Copay/Deductible Per Insured Person, Per Policy Year, and an additional $75 Copay/Deductible for each Emergency Room visit.

The first $200 of incurred covered medical expenses, that would otherwise be paid by the insurance company, is paid by you. Be sure that the insurance company receives receipts for all costs you incur so these expenses can be allocated towards meeting your deductible.

6) How do I get reimbursed for a prescription?

See the UnitedHealthcare Pharmacy Benefits section on page 8 for complete information on using the UnitedHealthcare Pharmacy Benefit.

7) What does this plan cover?

Please read the enclosed brochure for a complete summary of your benefits and for limitations on the coverage and on the schedule of benefits.

8) What is NOT COVERED on this plan?

Please read the additional Exclusions and Limitations carefully in this brochure and on the schedule of benefits.

9) How do I file a claim and who do I call with claim questions?

The UnitedHealthcare Options PPO providers and most hospitals and physicians will bill us directly for reimbursement, then bill you for any unpaid balance. If a provider wants you to pay for the charges up front, please send the complete itemized bill to UnitedHealthcare StudentResources, P.O. Box 809025, Dallas, Texas 75380-9025 for reimbursement. You do not need to complete a claim form when filing a claim. Please call 1-800-767-0700 for claim questions and inquiries.

10) Will this plan cover my pre-existing condition?

Yes.

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Student Health Center or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2) Claim forms are 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 from the time proof is otherwise required 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
1-800-767-0700
customerservice@uhcsr.com
claims@uhcsr.com

Sales/Marketing Services:

UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
727-563-3400
1-800-237-0903
E-Mail: info@uhcsr.com

Please keep this Certificate 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 Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

This Certificate is based on Policy # 2013-1404-2

WILLIAM & MARY®

v7-NOC 1 (10/28/2014)

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER:

NOTICE: 2013-1404-2
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 (10/28/2014)

- The SHC referral requirement is waived for routine vision benefits.