

# 2013-2014

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

## STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Domestic Students of



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



## **Notice Regarding Your Student Health Insurance Coverage**

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2012 and \$500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of \$500,000 for each Injury or Sickness that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-888-251-6243. 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**

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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 1-888-251-6243 or by visiting us at [www.uhcsr.com/bemidjstate](http://www.uhcsr.com/bemidjstate).

## **Eligibility**

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All domestic undergraduate students taking 6 or more credit hours are required to purchase this insurance Plan, unless the request for waiver form is completed and accepted. All domestic graduate students taking 3 or more credit hours and domestic post-graduate students taking credit hours are eligible to enroll in this insurance Plan.

Accident coverage for Intercollegiate Sports injuries is available under separate policy number 2013-1530-8.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study and correspondence courses do not fulfill the eligibility requirements that the Named Insured 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 eligible Dependents. Eligible Dependents are the student's spouse and dependent children under 26 years of age.

Dependent eligibility expires concurrently with that of the Insured student.

## **Effective and Termination Dates**

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The Master Policy on file at the school becomes effective at 12:01 a.m., August 26, 2013. 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., August 25, 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.

A student who requests to cancel coverage under the Policy will receive a refund of unearned premiums as of the time of cancellation if the unearned premium is for a period of more than one month. The return of unearned premium will be delivered to the Insured within 30 days following the receipt of the Insured's request for cancellation. The Policy is a Non-Renewable One Year Term Policy.

## **Extension of Benefits After Termination**

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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**

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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.

## Schedule of Medical Expense Benefits

### Injury and Sickness

**Maximum Benefit: Up To \$500,000 Paid as Specified Below  
(For Each Injury or Sickness)**

**Deductible: \$50 (For each Injury or Sickness)**

**Coinsurance Preferred Providers: 100% to \$2,500, then 80% thereafter**

**Coinsurance Out-of-Network Providers: 100% to \$2,500, then 80% thereafter**

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 \$500,000 for each Injury or Sickness.

The Preferred Provider for this plan is 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 Company will pay Covered Medical Expenses incurred at 100% up to \$2,500. After the Company has paid \$2,500, benefits will be paid for additional Covered Medical Expenses incurred at 80% not to exceed the Maximum Benefit of \$500,000 for each Injury or Sickness.

**Student Health Service Benefits:** The Deductible will be waived and benefits will be paid for 100% of Covered Medical Expense incurred at the Student Health Service. Contraceptives at the SHC are covered at 100% with \$0 Copay for Generics and 100% after a \$15 Copay for brand.

The following services MUST be obtained at Student Health Services: Office visit charge is limited to the professional fee for one travel, employment, school admission, or sports exam.

Dependents are not eligible to use the Student Health Services and therefore would be subject to the benefits and limitations described in the Schedule of Benefits.

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:

	<b>PA = Preferred Allowance</b>	<b>U&amp;C = Usual &amp; Customary Charges</b>
<b>INPATIENT</b>	<b>Preferred Providers</b>	<b>Out-of-Network Providers</b>
<b>Room and Board Expense</b> , daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	80% of PA	80% of U&C
<b>Intensive Care</b>	80% of PA	80% of U&C

INPATIENT	Preferred Providers	Out-of-Network Providers
<p><b>Hospital Miscellaneous Expenses</b>, 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.</p>	80% of PA	80% of U&C
<p><b>Routine Newborn Care</b>, 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.</p>	Paid as any other Sickness	
<p><b>Physiotherapy</b></p>	80% of PA	80% of U&C
<p><b>Surgeon's Fees</b>, 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.</p>	80% of PA	80% of U&C
<p><b>Anesthetist</b>, professional services administered in connection with Inpatient surgery.</p>	80% of PA	80% of U&C
<p><b>Registered Nurse's Services</b>, private duty nursing care.</p>	80% of PA	80% of U&C
<p><b>Physician's Visits</b>, non-surgical services when confined as an Inpatient.</p>	80% of PA	80% of U&C
<p><b>Pre-Admission Testing</b>, payable within 3 working days prior to admission.</p>	80% of PA	80% of U&C
OUTPATIENT		
<p><b>Surgeon's Fees</b>, 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.</p>	80% of PA	80% of U&C
<p><b>Anesthetist</b>, professional services administered in connection with outpatient surgery.</p>	80% of PA	80% of U&C
<p><b>Day Surgery Miscellaneous</b>, 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.</p>	80% of PA	80% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
<b>Physician's Visits</b> , benefits for Physician's Visits do not apply when related to Physiotherapy.	80% of PA	80% of U&C
<b>Medical Emergency Expenses</b> , use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	80% of PA	80% of U&C
<b>Diagnostic X-ray Services</b>	80% of PA	80% of U&C
<b>Laboratory Services</b>	80% of PA	80% of U&C
<b>Injections</b> , when administered in the Physician's office and charged on the Physician's statement.	80% of PA	80% of U&C
<b>Tests &amp; Procedures</b> , 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	80% of U&C
<b>Chemotherapy</b>	80% of PA	80% of U&C
<b>Radiation Therapy</b>	80% of PA	80% of U&C
<b>Physiotherapy</b> , see exclusion number 20 for additional Physiotherapy 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.	80% of PA	80% of U&C
<b>Prescription Drugs</b>	UnitedHealthcare Pharmacy (UHCP) \$15 Copay per prescription for Tier 1 / \$30 Copay per prescription for Tier 2 / 40% Coinsurance per prescription for Tier 3 / up to a 31 day supply per prescription	No Benefits



<b>OTHER</b>		
<b>Ambulance Services</b>	80% of PA	80% of U&C
<b>Dental Treatment</b> , made necessary by Injury to Sound, Natural Teeth only. ( <i>\$250 maximum per tooth</i> ). ( <i>Benefits are not subject to the \$500,000 Maximum Benefit.</i> )	80% of U&C	
<b>Consultant Physician Fees</b> , when requested and approved by the attending Physician.	80% of PA	80% of U&C
<b>Durable Medical Equipment</b> , 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.  <i>(\$1,000 maximum Per Policy Year. Durable Medical benefits payable under the \$1,000 maximum are not subject to the \$500,000 Maximum Benefit.)</i>	80% of PA	80% of U&C
<b>Maternity</b> , 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	
<b>Complications of Pregnancy</b>	Paid as any other Sickness	
<b>Elective Abortion</b> , ( <i>\$300 maximum</i> ) ( <i>Elective Abortion benefits are not subject to the \$500,000 Maximum Benefit.</i> )	80% of PA	80% of U&C
<b>Repatriation/Medical Evacuation</b>	Benefits provided by FrontierMEDEX	
<b>Substance Use Disorder Treatment</b> , services received on an Inpatient basis and on an outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered. ( <i>See Benefits for Alcoholism, Chemical Dependency and Drug Addiction</i> )	Paid as any other Sickness	
<b>Mental Illness Treatment</b> , services received on an Inpatient and outpatient basis. Benefits are limited to one visit per day. Institutions specializing in or primarily treating Mental Illness are not covered. ( <i>See also Benefits for Prescription Drug Coverage for Mental and Nervous Disorder</i> )	Paid as any other Sickness	
<b>Reconstructive Breast Surgery Following Mastectomy</b> , in connection with a covered Mastectomy. ( <i>See Benefits for Reconstructive Surgery</i> )	Paid as any other Sickness	
<b>Sexual Reassignment Surgery</b> , ( <i>\$25,000 Maximum Benefit Per Policy Year</i> ) ( <i>Cosmetic surgery, procedures and drugs are not covered even if related to sexual reassignment.</i> ) ( <i>Sexual Reassignment Surgery benefits are not subject to the \$500,000 Maximum Benefit.</i> )	Paid as any other Sickness	

OTHER	Preferred Providers	Out-of-Network Providers
<p><b>Diabetes Services</b>, 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.</p>	Paid as any other Sickness	
<p><b>Preventive Care Services</b>, 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 <i>United States Preventive Services Task Force</i>; 2) immunizations that have in effect a recommendation from the <i>Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</i>; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>.</p> <p>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.</p>	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 and/or Coinsurance that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable Copayments and/or Coinsurance. Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access [www.uhcsr.com/bemidjistate](http://www.uhcsr.com/bemidjistate) 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.

40% Coinsurance per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

If you do not present the card, you will need to pay the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit [www.uhcsr.com/bemidjstate](http://www.uhcsr.com/bemidjstate) and log in to your online account or call 1-855-828-7716.

## Definitions

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

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

## **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 physicians and hospitals who are members of 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 1-888-251-6243 or visiting [www.uhcsr.com/bemidjistate](http://www.uhcsr.com/bemidjistate) 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 50 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 covered at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Medical Expense Benefits. Preferred Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities. Call 1-888-251-6243 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 on 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 on 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**

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

### **Initial screening at first visit:**

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

**Each visit:** Urine analysis

**Once every trimester:** Hematocrit and Hemoglobin

**Once during first trimester:** Ultrasound

**Once during second trimester:**

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

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

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

**Once during third trimester:** Group B Strep Culture

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-888-251-6243.

## **Coordination of Benefits**

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Benefits will be coordinated with any other eligible medical, surgical or hospital plan or coverage so that combined payments under all programs will not exceed 100% of allowable expenses incurred for covered services and supplies.

## **Continuation Privilege**

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**NOTICE:** The purpose of this Continuation Privilege is to help eligible students avoid a break in coverage when away from school for a semester. **A break in coverage will cause the exclusion for pre-existing conditions to apply under the new policy offered by the school.**

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 4 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.

## **Mandated Benefits**

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### ***Benefits for Alcoholism, Chemical Dependency and Drug Addiction***

Benefits will be paid the same as any other Sickness for the treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident entitled to coverage hereunder when treatment is rendered in:

- 1) a licensed Hospital;
- 2) a residential treatment program as licensed by the state of Minnesota pursuant to diagnosis or recommendation by a Physician; and
- 3) a non-residential treatment program approved or licensed by the state of Minnesota.

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

### ***Benefits for Temporomandibular Joint Disorder and Craniomandibular Disorder***

Benefits will be paid the same as for treatment to any other joint in the body for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Treatment may be administered or prescribed by a Physician or dentist.

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

### ***Benefits for Scalp Hair Prosthesis***

Benefits will be paid for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata. Benefits are limited to \$350 per policy year, exclusive of any Deductible.

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

### ***Benefits for Phenylketonuria Treatment***

Benefits will be paid the same as any other Sickness for special dietary treatment for phenylketonuria when recommended by a Physician.

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

### ***Benefits for Cytologic Screening, Mammographic Examinations, Ovarian Cancer Surveillance Tests and Colorectal Screening Tests***

Benefits will be paid the same as any other Sickness for routine screening procedures for cancer and the office or facility visit, including mammograms and Pap smears, surveillance tests for women who are at risk for ovarian cancer, and colorectal screening tests for men and women when ordered or performed by a Physician in accordance with the standard practice of medicine.

"At risk for ovarian cancer" means:

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

"Surveillance tests for ovarian cancer" means annual screening using:

- 1.) CA-125 serum tumor marker testing;
- 2.) Transvaginal ultrasound;
- 3.) Pelvic examination; or
- 4.) Other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

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

### ***Benefits for Reconstructive Surgery***

Benefits will be paid the same as any other Injury or Sickness for reconstructive surgery when such service is incidental to or follows surgery resulting from Injury, Sickness or other diseases of the involved part or when such service is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician.

Benefits for reconstructive breast surgery following mastectomies is not limited as outlined above and must be provided if the mastectomy is medically necessary as determined by the attending Physician. Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and Insured.

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

### ***Benefits for Conditions Caused by Breast Implants***

Benefits will be paid the same as any other Sickness for conditions caused solely by breast implants.

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

### ***Benefits for Des Related Conditions***

Benefits will be paid the same as any other Sickness for conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

In the absence of credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no additional premium will be charged for such benefits.

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

### ***Benefits For Ventilator Dependency***

If the policy provides benefits for services provided by a private duty nurse or personal care assistant to a ventilator-dependent Insured Person in the person's home, benefits will be paid the same as any other Sickness for a maximum of 120 hours of services provided by a private duty nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a Hospital. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of 120 hours maximum to assure adequate training of the Hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

### ***Benefits for Child Health Supervision Services and Prenatal Care Services***

Benefits will be paid for the Usual and Customary Charges incurred for "child health supervision services" and "prenatal care services" exclusive of any Deductible, Copayment or other Coinsurance or dollar limitation requirements subject to the following guidelines.

Benefits shall be limited to one visit payable to one provider for all of the services provided at each visit subject to the schedule set forth below.

**"Child health supervision services"** means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months old to 72 months old.

**"Prenatal care services"** means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education and use of specialized skills and technology, when needed, as defined by Standards of Obstetric Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

### ***Benefits for Cleft Lip and Cleft Palate***

Benefits will be paid the same as any other Sickness for Dependent children under the limiting age for coverage for such Dependent, for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. If the policy extends Dependent coverage to children beyond age 19, benefits for those Dependent children age 19 up to the limiting age for coverage of such Dependent child are limited to inpatient and outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the Dependent child turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan, the dental plan shall be primary and this coverage shall be secondary. Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this policy.

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

### ***Benefits for Outpatient Services in Lieu of Hospitalization***

Benefits will be paid for the Covered Medical Expenses incurred for health care treatment or surgery performed on an outpatient basis at a facility equipped to perform these services in lieu of hospitalization whether or not the facility is part of a Hospital.

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



### ***Benefits for Emotionally Handicapped Children***

Benefits will be paid the same as any other Sickness for Dependent children for the treatment of emotionally handicapped children in a residential treatment facility licensed by the commissioner of human services. "Emotionally handicapped child" shall have the meaning set forth by the commissioner of human services in the rules and regulations relating to residential treatment facilities. This mandatory coverage under Section 62A.151 of the Minnesota Insurance Laws shall be on the same basis as the inpatient Hospital medical coverage provided under the policy.

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 for prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.

The screening must consist at a minimum of a prostate-specific antigen blood test and a digital rectal examination.

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

### ***Prescription Drug Coverage for Mental and Nervous Disorder***

If this policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Prescription Drug for antipsychotic drugs prescribed to treat Mental and Nervous Disorders.

If the Prescription Drug benefit utilizes a formulary, the following shall apply:

1. When the Physician prescribing the drug:
  - (a) indicates to the dispensing pharmacist, orally or in writing that the Prescription Drug must be dispensed as communicated; and
  - (b) certifies in writing to the Company that the Physician has considered all equivalent drugs in the Company's drug formulary and has determined that the drug prescribed will best treat the patient's condition.
2. When the Company receives a certification from the Physician as described above, the Company may not:
  - (a) impose a special deductible, co-payment, coinsurance, or other special payment requirement that the Company does not apply to drugs that are in the Company's drug formulary; or
  - (b) require written certification from the prescribing Physician each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.
3. Continuing care: Insureds receiving a prescribed drug to treat a diagnosed Mental and Nervous Disorder may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, copayment, coinsurance, or other special payment requirements, when the Company's drug formulary changes or an Insured changes health plans and the medication has been shown to effectively treat the Insured's condition.

In order to be eligible for this continuing care benefit:

- (a) the Insured must have been treated with the drug for 90 days prior to a change in the Company's drug formulary or a change in the Insured's health plan.
- (b) the Physician prescribing the drug indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated; and
- (c) the Physician prescribing the drug certifies in writing to the Company that the drug prescribed will best treat the patient's condition.

The continuing care benefit shall be extended annually when the Physician prescribing the drug:

- (a) indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated; and
  - (b) certifies in writing to the Company that the drug prescribed will best treat the patient's condition.
4. Exception to formulary. The Company must promptly grant an exception to the health plan's drug formulary for an Insured when the Physician prescribing the drug indicates to the Company that:
- (a) the formulary drug causes an adverse reaction in the Insured;
  - (b) the formulary drug is contraindicated for the Insured; or
  - (c) the Physician demonstrates to the Company that the Prescription Drug must be dispensed as written to provide maximum medical benefit to the Insured.

The Company is not required to provide coverage for a drug if the drug was removed from the Company's drug formulary for safety reasons.

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

### ***Benefits for Cancer Drug Coverage***

If this policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Prescription Drug for drugs for the treatment of cancer if the drug is recognized for treatment of cancer in one of the Standard Reference Compendia or in one article in Medical Literature.

"Standard reference compendia" means any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

"Off-label use of drugs" means when drugs are prescribed for treatments other than those stated in the labeling approved by the federal Food and Drug Administration.

"Medical literature" means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

Benefits include coverage of Medically Necessary services directly related to and required for appropriate administration of the cancer drug but does not include coverage of a drug not listed on the Company's drug formulary.

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

## Definitions

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**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.

**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.

**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, or an institution specializing in or primarily treating Mental Illness.

**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.

With respect to Mental Illness, Medical Necessity means those services appropriate, in terms of type, frequency, level, setting, and duration, to the Insured's diagnosis or condition, and diagnostic testing and preventive services. Medically Necessary Mental Illness services must be consistent with generally accepted practice parameters as determined by a Physician in the same or similar general specialty as typically manages the Mental Illness condition, procedure, or treatment at issue and must:

- 1) Help restore or maintain the Insured's health; or
- 2) Prevent the deterioration of the Insured's condition.

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

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

**PHYSICIAN** means a duly qualified licensed physician or any other provider of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws, other than a member of the person's immediate family.

The term "member of the immediate family" means husband, wife, children, father, mother, brother, sister, and the corresponding in-laws.

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

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

**PRE-EXISTING CONDITION** means any condition which is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

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

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

**USUAL AND CUSTOMARY CHARGES** means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of 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**

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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. Nicotine addiction, except as specifically provided in the policy;
3. Assistant Surgeon Fees;
4. Learning disabilities;
5. Biofeedback;
6. Circumcision;
7. Congenital conditions, except as specifically provided in the Benefits for Reconstructive Surgery, Benefits for Cleft Lip and Cleft Palate; or except as specifically provided for Newborn or adopted Infants;
8. 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;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery or Elective Treatment;
11. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses; except when due to a covered Injury or disease process;
12. Routine foot care including the care, cutting and removal of corns, calluses, bunions (except capsular or bone surgery);
13. Hearing examinations; hearing aids; 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;
14. Hirsutism;
15. Immunizations, except as specifically provided in the policy, preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
16. Injury caused by, contributed to, or resulting from being under the influence of any narcotic unless on the advice of and prescribed by the Insured Person's Physician;
17. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
18. 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;
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. Commission of or attempt to commit a felony;
22. Pre-existing Conditions in excess of \$500, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy provided the coverage was continuous to a date within 60 days prior to the Insured's effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;
23. 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;
  - c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in Benefits for Cancer Drug Coverage;
  - d) Products used for cosmetic purposes;
  - e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
  - f) Anorectics - drugs used for the purpose of weight control;
  - g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
  - h) Growth hormones; or
  - i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
24. 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; except as specifically provided in the policy
25. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
26. 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;
27. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
28. Nasal and sinus surgery; except for treatment of a covered Injury;
29. Bungee jumping or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
30. Sleep disorders;
31. Supplies, except as specifically provided in the policy;
32. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy;
33. Treatment in a Government hospital, unless there is an obligation for the Insured Person to pay for such treatment;

34. 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
35. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

## **Collegiate Assistance Program**

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



## **FrontierMEDEX: Global Emergency Assistance Services**

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

Domestic Students, insured spouse 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 Admission Hospital Payments
- \*Transportation After Stabilization
- \*Continuous Updates to Family and and Home Physician
- \*Emergency Travel Arrangements
- \*Replacement of Lost or Stolen Travel Documents
- \*Repatriation of Mortal Remains
- \*Transfer of Funds
- \*Translation Services

Please visit [www.uhcsr.com/bemidjistate](http://www.uhcsr.com/bemidjistate) 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](mailto:operations@frontiermedex.com).

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

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

FrontierMEDEX is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in MyAccount at [www.uhcsr.com/bemidjistate](http://www.uhcsr.com/bemidjistate) for additional information, including limitations and exclusions.

## **Online Access to Account Information**

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UnitedHealthcare **StudentResources** 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/bemidjistate](http://www.uhcsr.com/bemidjistate). 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 **StudentResources'** 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**

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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](http://my.uhcsr.com).

## **UnitedHealth Allies**

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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.

## **Notice of Appeal Rights**

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### **Right to Internal Appeal**

#### **Standard Internal Appeal**

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

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);

3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 1-888-251-6243 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 Claims Appeals at the following address:

Claims Appeals  
UnitedHealthcare **Student**Resources  
PO Box 809025  
Dallas, TX 75380-9025  
888-315-0447

### **Questions Regarding Appeal Rights**

Contact Customer Service at 1-888-251-6243 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

## **Claim Procedure**

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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) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the college or university under which the student is insured. A Company claim form is not required for filing a claim.
- 3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

### **The Plan is Underwritten by UnitedHealthcare Insurance Company**

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-888-251-6243

customerservice@uhcsr.com

claims@uhcsr.com

**For information on Dental Plans that may be available,  
please call 1-888-251-6243 or visit the Website at [www.uhcsr.com/bemidjistate](http://www.uhcsr.com/bemidjistate).**

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

**This Brochure is based on the following Policy Number:  
2013-1530-1**



**POLICY NUMBER: 2013-1530-1**

**NOTICE:**

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

**NOC # 1 8/26/13**

Removed the following paragraph from the SOB header: "Outpatient Physiotherapy benefits are payable only with a referral from your Student Health Service or 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."

**NOC # 2 9/6/13**

Removed the following wording from the Outpatient Physiotherapy benefit in the Summary of Benefits: "see Student Health Service Benefits on page 3 for limitations."