2013-2014

STUDENT INJURY AND SICKNESS INSURANCE PLAN

NOTE: METHODS OF DIAGNOSIS AND TREATMENT OF INFERTILITY ARE EXCLUDED FROM COVERAGE UNDER THIS POLICY.

LIMITED BENEFIT HEALTH INSURANCE COVERAGE

Designed Especially for the Students of

Connecticut Community-Technical Colleges

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

This Certificate does not provide Coverage for:

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.

Injury sustained while (a) participating in any 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.

UnitedHealthcare®
A UnitedHealth Group Company

12-BR-CT 06-201337-2

Notice Regarding Student Health Insurance Coverage

This 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. This student health insurance coverage puts a policy year limit of $500,000 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 an Insured Person 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 an Insured Person is 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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THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE INSURED AND NOT THE COMPANY IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE SPECIFIED IN THE SCHEDULE OF BENEFITS.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public 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 non-public personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or by visiting us at www.uhcsr.com.

Eligibility

All enrolled 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 in may also insure their Dependents. Eligible Dependents are the student's spouse (including a party to a civil union established according to Connecticut law) and dependent children under 26 years of age.

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 25, 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., August 24, 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.

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

The Policy is a Non-Renewable One Year Term Policy.

Premium Rates

Student	$1,330.00
Spouse	$3,656.00
All Children	$2,327.00

Extension of Benefits After Termination

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Totally Disabled 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 the "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.

Schedule of Medical Expense Benefits

Injury and Sickness

Up To $500,000 Maximum Benefit Paid as Specified Below (Per Insured Person) (Per Policy Year)

Deductible Preferred Provider: $1,000 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network: $2,000 (Per Insured Person, Per Policy Year)

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

Out-of-Pocket Maximum Preferred Providers: $10,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network: $15,000 (Per Insured Person, Per Policy Year)

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.

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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

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 and Customary Charges**

INPATIENT	Preferred Providers	Out-of-Network Providers
Room and Board Expense, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	80% of PA	60% of U&C
Intensive Care	80% of PA	60% of U&C
Hospital Miscellaneous Expenses, 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	60% of U&C

INPATIENT	Preferred Providers	Out-of-Network Providers
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. *(See also Benefits for Postpartum Care)*	Paid as any other Sickness	
Physiotherapy	80% of PA	60% 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	60% of U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	60% of U&C
OUTPATIENT		
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of U&C
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	80% of PA	60% of U&C
Physiotherapy, see exclusion number 26 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, unless excluded in the policy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of PA	60% of U&C
Medical Emergency Expenses, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	80% of PA	60% of U&C
Diagnostic X-ray Services	80% of PA	60% of U&C
Radiation Therapy	80% of PA	60% of U&C
Chemotherapy	80% of PA	60% of U&C
Laboratory Services	80% of PA	60% 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	60% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Prescription Drugs	UnitedHealthcare Pharmacy (UHCP) $15 Copay per prescription for Tier 1 $35 Copay per prescription for Tier 2 $40 Copay per prescription for Tier 3 up to a 31 day supply per prescription *(Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.)*	$15 Deductible per prescription for generic drugs $35 Deductible per prescription for brand name up to a 31 day supply per prescription
OTHER		
Ambulance Services, Medically Necessary transport.	Maximum allowable rate established by the Department of Public Health	
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. *($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum are not included in the $500,000 Maximum Benefit.)*	80% of PA	60% of U&C
Consultant, when requested and approved by the attending Physician.	80% of PA	60% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *(See also Benefits for Inpatient Dental Services)*	80% of PA	80% of U&C
Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier. *(See also Benefits for Postpartum Care)*	Paid as any other Sickness	

OTHER	Preferred Providers	Out-of-Network Providers
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	No Benefits	
Home Health Care	See Benefits for Home Health Care	
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
Reconstructive Breast Surgery Following Mastectomy	See Benefits for Reconstructive Breast Surgery	
Diabetes Services, see Benefits for Diabetes and Benefits for Diabetic Outpatient Self-Management Training.	Paid as any other Sickness	
Mental Illness Treatment, services received on an Inpatient and outpatient basis. See also Benefits for Mental or Nervous Conditions.	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. See also Benefits for Mental or Nervous Conditions.	Paid as any other Sickness	
Approved Clinical Trials, *(See Benefits for Clinical Trials).*	Paid as any other Sickness	

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 Choice Plus.**

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.

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

Inpatient Expenses

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

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.

Prescription Drugs Products which require notification are:

Actiq, Anzemet, Avita-Penderm, Avodart, Copegus, Differin-Gladerma, Diflucan, Elidel, Emend, Genotropin, Humatrope, Increlex, Infergen, Intron-A, Iplex, Kytril, Lamisil, Lotronex, Norditropin, Nutropin, Nutropin AQ, Nutropin Depot, PEG-Intron, Pegasys, Proscar, Protopic, Protropin, Provigil, Raptiva, Regranex, Relenza, Retin-A, Retin-A Micro Ortho, Rebetol, Rebetron, Restasis, Revatio, Roferon, Sporanox, Saizen, Serostim, Tamiflu, Tazorac, Tracleer, Ventavis, Wellbutrin SR, Wellbutrin XL, Zelnorm, Zofran, Zorbtive.

You are responsible for paying the applicable Copayment. 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 or call 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.

$35 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

$40 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 present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com and log in to your online account or call 855-828-7716.

When prescriptions are filled at pharmacies outside the network, the Insured must pay for the prescriptions out-of-pocket and submit the receipts for reimbursement to UnitedHealthcare **Student**Resources, P.O. Box 809025, Dallas, TX 75380-9025. See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.

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 re available in over-the-counter form or equivalent unless a Medical Necessity. 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.

Definitions

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

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service 1-855-828-7716.

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	$5,000
Two or More Members	$5,000
One Member	$2,500
Thumb or Index Finger	$1,250

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.

Mandated Benefits

Benefits for Accidental Ingestion of a Controlled Drug

Benefits will be paid for accidental ingestion or consumption of a controlled drug as required by Connecticut statute. When inpatient treatment in a Hospital, whether or not operated by the State, is required as a result of accidental ingestion or consumption of a controlled drug, benefits will be paid for the Usual and Customary Charges incurred up to a maximum of 30 days Hospital Confinement. Benefits will be paid for outpatient treatment resulting from accidental ingestion or consumption of a controlled drug for any one accident.

Benefits for Hypodermic Needles or Syringes

Benefits will be paid for the Usual and Customary Charges incurred for hypodermic needles or syringes prescribed by a licensed Physician for the purpose of administering medications for any Injury or Sickness, provided such medications are covered under the policy.

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

Benefits for Home Health Care

Benefits will be paid as specified below for Injury or Sickness for home health care to residents in Connecticut.

Benefits payable shall be limited to eighty visits in any calendar year or in any continuous period of twelve months for each Insured. Each visit by a representative of a home health agency shall be considered as one Home Health Care visit; four hours of home health aide service shall be considered as one Home Health Care visit.

Home Health Care benefits are subject to an annual Deductible of fifty dollars ($50.00) for each Insured and will be subject to a Coinsurance provision of not less than seventy-five percent (75%) of the Usual and Customary Charges for such services. If an Insured is eligible for Home Health Care coverage under more than one policy, the Home Health Care benefits shall only be provided by that Policy which would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

“Home Health Care” means the continued care and treatment of an Insured Person who is under the care of a Physician if:

(1) continued hospitalization would otherwise have been required if Home Health Care was not provided, except in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of six months or less to live, and,

(2) the plan covering the Home Health Care is established and approved in writing by such Physician within seven days following termination of a hospital confinement as a resident Inpatient for the same or a related condition for which the Insured was hospitalized, except that in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such Insured was so confined or, if such Insured was so confined, irrespective of such seven-day period, and

(3) such Home Health Care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live.

Home Health Care shall be provided by a home health agency. "Home health agency" means an agency or organization which meets each of the following requirements:

(1) It is primarily engaged in and is federally certified as a home health agency and duly licensed by the appropriate licensing authority to provide nursing and other therapeutic services.

(2) Its policies are established by a professional group associated with such agency or organization, including at least one Physician and at least one Registered Nurse, to govern the services provided.

(3) It provides for full-time supervision of such services by a Physician or by a Registered Nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an administrator.

Home Health Care shall consist of, but shall not be limited to, the following:

(1) Part-time or intermittent nursing care by a Registered Nurse or by a licensed practical nurse under the supervision of a Registered Nurse, if the services of a Registered Nurse are not available;

(2) Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a Registered Nurse or licensed practical nurse;

(3) Physical, occupational or speech therapy;

(4) Medical supplies, drugs and medicines prescribed by a Physician and laboratory services to the extent such charges would have been covered under the Policy or contract if the Insured had remained or had been confined in the Hospital;

(5) Medical social services provided to or for the benefit of a covered person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live. "Medical social services" mean services rendered, under the direction of a Physician by a qualified social worker, including but not limited to:

(A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment;

(B) appropriate action and utilization of community resources to assist in resolving such problems;

(C) participation in the development of the overall plan of treatment for such Insured

Benefits shall be subject to all other limitations and provisions of the policy.

Benefits for Mental or Nervous Conditions

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Mental Illness and Substance Use Disorders.

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

Benefits for Treatment of Tumors and Leukemia

Benefits will be paid the same as any other Sickness for the surgical removal of tumors and for treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any non-dental prosthesis, including any maxillofacial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, and a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.

Benefits Per Policy Year shall be at least $300.00 for prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for prosthesis shall be at least $300.00 for each breast removed, and $350.00 for a wig.

If the policy provides benefits for Prescription Drugs, benefits will be provided for prescribed orally administered anticancer medications on a basis that is no less favorable than intravenously administered anticancer medications.

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

Benefits for Reconstructive Breast Surgery

Benefits will be paid for the Usual and Customary Charges incurred for reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Benefits shall be provided for at least forty eight hours of Inpatient care following a mastectomy or lymph node dissection, and may provide for a longer period of Inpatient care if such care is recommended by the Insured's Physician.

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

Benefits for Mammography and Comprehensive Ultrasound Screening

Benefits will be paid the same as any other Covered Medical Expenses as shown on the Schedule of Benefits for mammographic examinations to any woman insured under this policy which are equal to the following requirements: 1) a baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and 2) a mammogram every year for any woman who is forty years of age or older.

Additional benefits will be provided for comprehensive ultrasound screening and magnetic resonance imaging, in accordance with guidelines established by the American Cancer Society or the American College of Radiology, of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's Physician or advanced practice Registered Nurse.

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

Benefits for Prostate Cancer Testing

Benefits will be paid the same as any other Sickness for laboratory and diagnostic tests, including, but not limited to, prostate specific antigen (PSA) tests to screen for prostate cancer for Insureds who are symptomatic, or whose biological father or brother has been diagnosed with prostate cancer, and for all Insureds fifty (50) years of age or older.

Benefits will also be paid for the treatment of prostate cancer, provided such treatment is Medically Necessary and in accordance with guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

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

Benefits for Ostomy Appliances and Supplies

Benefits will be paid for the Usual and Customary Charges for Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors up to a maximum benefit of $2,500.00 per Policy Year.

“Ostomy" shall include colostomy, ileostomy and urostomy.

Benefits shall not be applied to any Durable Medical Equipment benefit maximum. Benefits shall be subject to all other Deductible, Copayments, 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, including, but not limited to: (1) an annual fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American College of Gastroenterology, after their consultation with the American Cancer Society and the American College of Radiology, based on the ages, family histories and frequencies provided in the recommendations.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy; however, benefits will not be subject to any Deductible, Copayments, Coinsurance or out of pocket expense for any additional colonoscopy services ordered by a Physician within a policy year.

Benefits for Cancer Clinical Trial

Benefits will be paid the same as any other Sickness for the Routine Patient Care Costs associated with Clinical Trials.

“Clinical Trial” means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic diseases in Insured Persons.

“Routine Patient Care Costs” means: 1) Medically Necessary health care services that are incurred as a result of treatment being provided to the Insured for purposes of the Clinical Trial that would otherwise be covered if such services were not rendered pursuant to a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Insured during the course of treatment in the Clinical Trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the Insured were not enrolled in a Clinical Trial; and 2) costs incurred for Prescription Drugs provided to the Insured, provided such Prescription Drugs have been approved for sale by the federal Food and Drug Administration. If the policy provides Preferred Provider benefits, such hospitalization shall include treatment at an Out-of-Network facility if such treatment is not available at a Preferred Provider Hospital and not eligible for reimbursement by the sponsors of such Clinical Trial.

Routine Patient Care Costs shall not include: 1) the cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration; 2) the cost of a non-health care service that an Insured may be required to receive as a result of the treatment being provided; 3) facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial; 4) costs of services that are: a) inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis; or b) performed specifically to meet the requirements of the Clinical Trial; 5) costs that would not be covered under the Insured's policy for investigational treatments, including, but not limited to, items excluded from coverage under this policy; and 6) transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial for the Insured or any family member or companion.

The Company may require that the person or entity seeking coverage for the Clinical Trial provide: 1) evidence satisfactory to the Company that the Insured receiving coverage meets all of the patient selection criteria for the clinical trial, including credible evidence in the form of clinical or pre-clinical data showing that the Clinical Trial is likely to have a benefit for the Insured Person that is commensurate with the risks of participation in the Clinical Trial to treat the Insured Person's condition; and 2) evidence that the appropriate informed consent has been received from the Insured; and 3) copies of any medical records, protocols, test results or other clinical information used by the Physician or institution seeking to enroll the Insured in the Clinical Trial; and 4) a summary of the anticipated Routine Patient Care Costs in excess of the costs for standard treatment; and 5) information from the Physician or institution regarding those items, including any Routine Patient Care Costs, that are eligible for reimbursement by an entity other than the Company, including the entity sponsoring the Clinical Trial; and 6) any additional information that may be reasonably required for the review of a request for coverage of the Clinical Trial. The Company shall request any additional information about a Clinical Trial not later than five business days after receiving a request for coverage from an Insured Person or a Physician seeking to enroll an Insured in a Clinical Trial.

A Clinical Trial for the prevention of cancer shall be eligible for coverage only if it involves a therapeutic intervention, is a phase III Clinical Trial approved by one of the entities identified below and is conducted at multiple institutions. In order to be eligible for coverage of Routine Patient Care Costs, a Clinical Trial shall be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: 1) one of the National Institutes of Health; or 2) a National Cancer Institute affiliated cooperative group; or 3) the federal Food and Drug Administration as part of an investigational new drug or device exemption; or 4) the federal Department of Defense or Veterans Affairs; or 5) qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy established under the September 19th, 2000, Medicare National Coverage Determination, as amended from time to time. Benefits will not be provided for any single institution Clinical Trial conducted solely under the approval of the institutional review board of an institution, or any trial that is no longer approved by an entity identified herein

The provider, Hospital or institution seeking coverage for the Routine Patient Care Costs shall submit to the Company the standardized request for coverage form as developed by the Connecticut Insurance Department to request approval for Clinical Trial benefits. The Company shall not accept any other approval request form other than the standardized request for coverage form. Upon receipt of the standardized form, the Company shall approve or deny coverage for such services not later than five business days after receiving such request and any other reasonable supporting materials requested by the Company, except that if the Company utilizes independent experts to review such requests, it shall respond not later than ten business days after receiving such request and supporting materials.

The Insured, or the provider with the Insured's written consent, may appeal any denial of coverage for Medical Necessity to an external, independent review pursuant to section 39a-478n of the general statutes. Such external review shall be conducted by a properly qualified review agent whom the Connecticut Department of Insurance has determined does not have a conflict of interest regarding the Clinical Trial.

The Company shall not provide coverage for Routine Patient Care Costs that are eligible for reimbursement by an entity other than the Company, including the entity sponsoring the Clinical Trial.

Routine Patient Care Costs shall be subject to the same Deductibles, Copayments, Coinsurance, terms, conditions, restrictions, exclusions and limitations of the policy, including limitations on out-of-network care, except that treatment at an out-of-network Hospital shall be made available by the out-of-network Hospital and the Company at no greater cost to the Insured than if treatment was available at a Preferred Provider Hospital

Benefits for Postpartum Care

If an Insured and Newborn Infant are discharged from Inpatient care less than forty-eight hours after a vaginal delivery or less than ninety-six hours after a cesarean delivery, benefits will be provided on the same basis as any other Covered Medical Expenses as shown on the Schedule of Benefits for a follow-up visit within forty-eight hours of discharge and an additional follow-up visit within seven days of discharge. Any decision to shorten the length of Inpatient stay to less than forty-eight hours after a vaginal delivery or ninety-six hours after a cesarean delivery shall be made by the Physician after conferring with the Insured.

Follow-up services shall include, but not be limited to, physical assessment of the Newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any Medically Necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and Newborn pediatric care.

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

Benefits for Amino Acid Modified Preparations and Low Protein Modified Food Products

Benefits will be paid the same as any other outpatient Prescription Drug for Amino Acid Modified Preparations and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases if the Amino Acid Modified Preparations or Low Protein Modified Food Products are prescribed for the therapeutic treatment of Inherited Metabolic Diseases and are administered under the direction of a Physician.

If the policy does not provide benefits for outpatient Prescription Drugs, benefits will be provided subject to the policy maximum benefit including any Deductible, Copayment or Coinsurance requirements.

"Inherited Metabolic Disease" means: (A) disease for which newborn screening is required under Connecticut Statute Title 38a, Chapter 700c, Section 19a-55; and (B) Cystic Fibrosis.

"Low Protein Modified Food Product means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

"Amino Acid Modified Preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

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

Benefits for Specialized Formulas

Benefits will be paid the same as any other outpatient Prescription Drug for medically necessary Specialized Formulas for Dependent children up to age twelve when such specialized formulas are for the treatment of a condition for which newborn screening is required under section 19a-55 of the Public Health and Well Being Regulation.

If the policy does not provide benefits for outpatient Prescription Drugs, benefits will be provided subject to the policy maximum benefit including any Deductible, Copayment or Coinsurance requirements.

"Specialized Formula" means a nutritional formula for children up to age twelve that is exempt from the general requirement for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific disease.

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

Benefits for Diabetes

Benefits will be paid the same as any other Sickness for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include Medically Necessary equipment, in accordance with the Insured Person's treatment plan, drugs and supplies prescribed by a Physician.

If the policy contains a Prescription Drugs maximum benefit, diabetic insulin and supplies shall not be subject to the Prescription Drugs maximum benefit specified in the Schedule of Benefits. Benefits shall be subject to all other Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Diabetic Outpatient Self Management Training

Benefits will be paid the same as any other Sickness for outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if the training is prescribed by a Physician. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a Physician, as defined in the Policy, trained in the care and management of diabetes and authorized to provide such care within the scope of the Physician's practice.

Covered Medical Expenses shall include:

1) Initial training visits provided to an Insured after the Insured is initially diagnosed with diabetes that is Medically Necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, up to a maximum of ten hours.
2) Training and education that is Medically Necessary as a result of a subsequent diagnosis by a Physician of a significant change in the Insured's symptoms or condition which requires modification of the Insured's program of self-management of diabetes, up to a maximum of four hours.
3) Training and education that is Medically Necessary because of the development of new techniques and treatment for diabetes up to a maximum of four hours.

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

Benefits for Lyme Disease Treatment

Benefits will be paid the same as any other Sickness for Lyme disease treatment including not less than thirty days of intravenous antibiotic therapy, sixty days of oral antibiotic therapy, or both, and shall provide benefits for further treatment if recommended by a Physician.

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

Benefits for Inpatient Dental Services

Benefits will be paid the same as any other Sickness for general anesthesia, nursing and related Hospital services provided in conjunction with Inpatient, outpatient or one day dental services if the following conditions are met:

1) The anesthesia, nursing and related Hospital services are deemed Medically Necessary by the treating Physician.
2) The Insured is either a) a person who is determined by a Physician to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a Hospital, or b) a person who has a developmental disability, as determined by a Physician, that places the person at serious risk.

The expense of anesthesia, nursing and related Hospital services shall be deemed a Covered Medical Expense and shall not be subject to any limits on dental benefits in the Policy.

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

Benefits for Treatment of Craniofacial Disorders

Benefits will be paid the same as any other Sickness for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Insureds eighteen years of age or younger. The processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No benefits are provided for cosmetic surgery.

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

Benefits for Pain Management

Benefits will be paid the same as any other Sickness for Pain treatment ordered by a Pain Management Specialist, which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

“Pain” means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves, and “Pain Management Specialist” means a Physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

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

Benefits for Isolation Care and Emergency Care

Benefits will be paid the same as any other Injury or Sickness for isolation care and emergency services provided by the state’s mobile field Hospital.

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

Benefits for Infertility Treatment

Benefits will be paid the same as any other Sickness for an Insured Person for the medically necessary expenses of the diagnosis and treatment of Infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. Such infertility treatment must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

For the purposes of this section "Infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period.

Benefits are subject to the following limitations:

1) Benefits are available up to the Insured Person's fortieth (40) birthday.
2) Benefits for ovulation induction are subject to a lifetime limit of four (4) cycles.
3) Benefits for intrauterine insemination are subject to a lifetime limit of [three (3)] cycles.
4) Benefits for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer, and tubal ovum transfer are subject to a lifetime limit of two (2) cycles, with not more than two (2) embryo implantations per cycle.
5) Benefits for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer are payable only to those Insured Persons who:
    a) Have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered by this policy. However benefits will not be denied on this basis for any Insured Person who foregoes a particular infertility treatment or procedure if the Insured Person's Physician determines that such treatment or procedure is likely to be unsuccessful.
6) Have been covered under the school's student insurance policy for at least 12 months.
7) Provide disclosure of any previous infertility treatment or procedures for which such Insured Person received coverage under a different health insurance policy.

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

Benefits for Hearing Aids for Children

Benefits will be paid for Medically Necessary hearing aids for Dependent children ages twelve years or younger. Such hearing aids shall be considered Durable Medical Equipment and shall be limited to a maximum benefit of $1000.00 within a twenty-four month period.

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

Benefits for Early Intervention Services

Benefits will be paid as determined by the schedule published by the Director of Connecticut's Birth to Three program for Medically Necessary Early Intervention Services for Dependent Eligible Children, from birth until the child's third birthday, that are provided as part of an Individualized Family Service Plan pursuant to Title 17a of the Social and Human Services and Resources, Chapter 319b, Department of Developmental Services, section, 17a-248e, up to a maximum benefit of $6,400.00 per child per calendar year and an aggregate benefit of $19,200.00 per child over the total three-year period. Benefits paid under this benefit shall not be applied to any Policy Year maximum specified in the Policy.

To the extent that an Early Intervention Service falls into one of the essential benefit categories issued by the Affordable Care Act (ACA) the maximum and aggregate benefit limit will not be applied.

"Early intervention services" means early intervention services, as defined in 34 CFR Part 303.12, as from time to time amended.

"Eligible children" means Dependent children from birth to thirty-six months of age, who are not eligible for special education and related services pursuant to sections 10-76a to 10-76h, inclusive, as amended, and who need Early Intervention Services because such children are: (A) Experiencing a significant developmental delay as measured by standardized

diagnostic instruments and procedures, including informed clinical opinion, in one or more of the following areas: (1) cognitive development; (2) physical development, including vision or hearing; (3) communication development; (4) social or emotional development; or (5) adaptive skills; or (B) Diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay.

"Individualized family service plan" means a written plan for providing Early Intervention Services to an Eligible Child and the child's family after completion of an evaluation.

"Evaluation" means a multidisciplinary professional, objective assessment conducted by appropriately qualified personnel in order to determine a child's eligibility for Early Intervention Services.

The policy Deductible, Copayment, Coinsurance limitations, or any other limitations will not be applied to this benefit.

Benefits for Neuropsychological Testing for Children with Cancer

Benefits will be paid the same as any other Sickness without prior authorization for each Dependent child diagnosed with cancer, for neuropsychological testing ordered by a licensed Physician, to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.

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

Benefits for Autism Spectrum Disorders

Benefits will be paid the same as any other Sickness for physical therapy, speech therapy, and occupational therapy services for the treatment of Autism Spectrum Disorders, as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

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

Benefits for Epidermolysis Bullosa Treatment

Benefits will be paid for the Usual and Customary Charges for wound-care supplies that are Medically Necessary for the treatment of Epidermolysis Bullosa provided such benefits are administered under the direction of a Physician.

"Epidermolysis Bullosa" is a genetic disorder caused by a mutation in the keratin gene. The disorder is characterized by the presence of extremely fragile skin and recurrent blister formation, resulting from minor mechanical friction or trauma.

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

Benefits for Human Leukocyte Antigen Testing

Benefits will be paid the same as any other Sickness for expenses arising for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantations.

Such testing shall be performed in a facility a) accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and b) certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time.

Benefits are limited to Insured Persons who, at the time of such testing, complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy; however, any Deductible, Copayment, Coinsurance or other out of pocket expense shall not exceed 20% of the cost of the testing Per Policy Year.

Benefits for Blood Lead Screening

Benefits will be paid for the Usual and Customary Charges for blood lead screening and risk assessment ordered by an Insured's primary Physician.

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

Definitions

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the 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.

INJURY means accidental bodily injuries sustained by the Insured Person which: 1) are the direct cause, independent of disease or bodily infirmity or any other cause; 2) are treated by a Physician within 30 days after the date of accident; and occurs while this policy is in force, subject to the policy Pre-existing Condition provisions. 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, subject to the policy Pre-existing Condition provisions.

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.

MEDICAL NECESSITY means health care services that a Physician, exercising prudent clinical judgement, would provide to an Insured for the purpose of preventing, evaluating, diagnosing or treating Sickness, Injury, or its symptoms, and that are:

1) In accordance with Generally Accepted Standards of Medical Practice;
2) Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Insured's Sickness or Injury; and
3) Not primarily for the convenience of the Insured, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Insured's Sickness or Injury.

For the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgement.

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

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

PRE-EXISTING CONDITION means any condition which is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under the policy. Routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a pre-existing condition.

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy, subject to the policy Pre-existing Condition provisions. 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.

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Insured unable to actively attend class. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

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. Acne;
2. Acupuncture;
3. Allergy including allergy testing;
4. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the Benefits for Early Intervention Services;
5. Biofeedback;
6. Congenital conditions, except as specifically provided for Newborn or adopted Infants;

7. 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;
8. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;
9. Dental treatment, except as specifically provided in the Policy;
10. Elective Surgery or Elective Treatment;
11. Elective abortion;
12. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
13. Flat foot conditions; supportive devices for 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);
14. Health spa or similar facilities; strengthening programs;
15. Hearing examinations; hearing aids, except as specifically provided in the Benefits for Hearing Aids for Children; 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;
16. Hirsutism; alopecia;
17. Hypnosis;
18. 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;
19. For Accidental Death and Dismemberment Benefit only, no indemnity will be paid for loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his Physician for the Insured;
20. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
21. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except for a Medical Emergency when traveling for academic study abroad programs, business or pleasure;
22. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
23. Injury sustained while (a) participating in any 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;
24. Investigational services;
25. Lipectomy;
26. 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;

27. Participation in a riot, civil disorder or a felony, except when Injury occurs when the Insured Person has an elevated blood alcohol content or when under the influence of intoxicating liquor or any drug or both. Participation means to voluntarily take a part or share with others assembled together in some activity. Riot means a violent public disturbance of the peace by a number of persons assembled together;
28. Pre-existing Conditions for a period of 12 months, except for congenital anomalies of a Newborn Infant; or, except for individuals who have been continuously insured under the student insurance policy for at least 12 consecutive months. Credit will be given for Pre-existing Conditions for newly Insured Persons who were covered under previous Qualifying Coverage, but not covered for such Pre-existing Conditions under the Qualifying Coverage when (a) the preceding Qualifying Coverage was continuous to a date not less than 120 days prior to their effective date under this policy; and for (b) newly Insured Persons who apply within 30 days of initial eligibility under this policy and whose previous Qualifying Coverage was terminated due to the involuntary loss of employment and was continuous to a date not more than 150 days prior to their effective date under this policy. This Pre-existing Condition Limitation will not apply to newly Insured Persons who were covered for such Pre-existing Conditions, under previous Qualifying Coverage when (a) the preceding Qualifying Coverage was continuous to a date not less than 120 days prior to their effective date under this policy; or (b) newly Insured Persons who apply within 30 days of initial eligibility under this policy and whose previous Qualifying Coverage was terminated due to the involuntary loss of employment and was continuous to a date not more than 150 days prior to their effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;
29. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, and syringes, except for hypodermic needles or syringes prescribed by a Physician for the purpose of administering medications for medical conditions, provided such medications are covered under the policy, support garments and other non-medical substances, except as specifically provided in the policy;
    b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association’s Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacist’s American Hospital Formulary Service Drug Information (AHFS-DI) ;
    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; except as specifically provided in the Benefits for Infertility Treatment;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

30. 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, except as specifically provided in the Benefits for Infertility Treatment; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
31. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except for a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the Sickness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a Phase III clinical trial of the Federal Food and Drug Administration; or except as specifically provided in the policy;
32. Routine Newborn Infant Care, well-baby nursery and related Physician charges, except as specifically provided in the policy;
33. 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;
34. Services provided without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee for which the Insured is not charged;
35. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except as specifically provided in the Benefits for Treatment of Craniofacial Disorders; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
36. 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;
37. Sleep disorders;
38. Speech therapy; naturopathic services;
39. Unless specifically covered under Benefits for Mental or Nervous Conditions, Injury resulting from suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
40. Supplies, except as specifically provided in the policy;
41. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Benefits for Reconstructive Breast Surgery and Benefits for Treatment of Tumors and Leukemia;
42. Treatment in a Government hospital for which the Insured is not charged, unless there is a legal obligation for the Insured Person to pay for such treatment;
43. 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
44. Weight management, weight reduction, nutrition programs, treatment for obesity, and surgery for removal of excess skin or fat.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the 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 Medical Assistance

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:

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

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 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 FrontierMEDEX ID Number as listed on your Medical ID Card;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached.

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

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

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

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

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

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

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

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

Right to External Independent Review

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

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

Standard External Review

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

Expedited External Review

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

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
   a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
   b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and
   a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
   b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

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 made in writing to the Commissioner, and shall be accompanied by a $25.00 filing fee, except that no Insured Person or Authorized Representative shall pay more than $75.00 in a Policy Year. If the Commissioner finds that the Insured Person is indigent or unable to pay the filing fee, the Commissioner shall waive such fee. Upon request of an External Review, the Commissioner shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review. All External Review requests shall be submitted to the Commissioner at the following address:

Connecticut Insurance Department

ATTN: External Appeals

PO Box 816

Hartford, CT 06142-0816

(860) 297-3910

Questions Regarding Appeal Rights

Contact Customer Service 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:

Connecticut Office of the Healthcare Advocate

P.O. Box 1543

Hartford, CT 06144

(866) 466-4446

www.ct.gov/oha

healthcare.advocate@ct.gov

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.

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.

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.

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the college under which the student is insured. A Company claim form is not required for filing a claim.
3) File claim within 30 days of Injury or first onset of Sickness. should must 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

1-800-767-0700

Customerservice@uhcsr.com

claims@uhcsr.com

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

This Certificate is based on Policy Number:

2013-201337-2

Connecticut Community-Technical Colleges

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