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COVER FOR DETAILS

UNIVERSITY  
*of* ALASKA  
*Many Traditions One Alaska*

Graduate Student  
Injury and Sickness  
Insurance Plan  
2013-2014

Designed Especially for  
the Graduate Students of



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



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

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2012 and \$500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of \$500,000 for each Injury or Sickness that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-888-344-5989. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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## **Privacy Policy**

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We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-888-344-5989 or visiting us at [www.uhcsr.com](http://www.uhcsr.com).

## **Eligibility**

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All students enrolled in a UAF, UAA or UAS Graduate program and are paid a stipend are required to be enrolled in this insurance Plan. The premium is paid by the University on behalf of the student. Enrollment is not automatic. Graduate students must come to the Office of the Graduate School and show a copy of their contract letter to complete the enrollment process.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. 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 and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse (husband or wife) or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Brochure for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student participant.

## **Effective and Termination Dates**

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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.

If paying premiums by semester, coverage expires as follows:

Annual	08-25-2013 to 08-24-2014
Fall	08-25-2013 to 01-04-2014
Spring	01-05-2014 to 05-16-2014
Spring/Summer	01-05-2014 to 08-24-2014
Summer	05-17-2014 to 08-24-2014

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 14 days after the coverage expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

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

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

## Premium Rates

	Domestic or International	Spouse or Domestic Partner	Each Child	All Children
Annual	\$2,087	\$6,976	\$2,987	\$6,876
Fall	\$761	\$2,542	\$1,088	\$2,505
Spring	\$754	\$2,523	\$1,080	\$2,487
Spring/Summer	\$1,326	\$4,434	\$1,899	\$4,371
Summer	\$572	\$1,911	\$819	\$1,884

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

## Extension of Benefits After Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the termination date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

## Pre-Admission Notification

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

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

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

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

# Schedule of Medical Expense Benefits

## Injury and Sickness

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

**Deductible: \$300 (For Each Injury or Sickness)  
Deductible: \$600 (For all Insureds in a Family, Per Policy Year)**

**Coinurance Preferred Provider: 80% except as noted below  
Coinurance Out-of-Network: 80% except as noted below**

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. Covered Medical Expense incurred at a Preferred Provider facility by an Out-of-Network Provider will be paid at the Preferred Provider level of benefits when the Out-of-Network Provider performs the services as part of a covered stay and the Insured Person is not given a choice as to who performs the services. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of \$500,000 for each Injury or Sickness.

Usual and Customary Charges are based on data provided by FAIR Health, Inc. using the 80th percentile based on location of the Policyholder.

Graduate students paid a stipend, assigned to remote Alaskan locations by the university, without access to the Student Health and Counseling Center will have the policy Deductible waived for Covered Medical Expenses under the plan.

**Student Health Center Benefits:** The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health and Counseling Center and benefits are not subject to the Policy exclusions.

No benefits are available under this plan for any expenses associated with a period when there is no coverage. For example, prescriptions (such as birth control) will only be covered during the period when coverage is in effect.

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

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

INPATIENT	Preferred Providers	Out-of-Network Providers
<b>Hospital Miscellaneous Expense</b> , such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	80% of U&C
<b>Routine Newborn Care</b> , while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
<b>Physiotherapy</b>	80% of PA	80% of U&C
<b>Surgeon's Fees</b> , if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	80% of U&C
<b>Assistant Surgeon</b>	80% of PA	80% of U&C
<b>Anesthetist</b> , professional services administered in connection with Inpatient surgery.	80% of PA	80% of U&C
<b>Registered Nurse's Services</b> , private duty nursing care.	No Benefits	
<b>Physician's Visits</b> , non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	80% of U&C
<b>Pre-Admission Testing</b> , payable within 3 working days prior to admission.	80% of PA	80% of U&C



OUTPATIENT	Preferred Providers	Out-of-Network Providers
<p><b>Surgeon's Fees</b>, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.</p>	80% of PA	80% of U&C
<p><b>Day Surgery Miscellaneous</b>, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.</p>	80% of PA	80% of U&C
<p><b>Assistant Surgeon</b></p>	80% of PA	80% of U&C
<p><b>Anesthetist</b>, professional services administered in connection with outpatient surgery.</p>	80% of PA	80% of U&C
<p><b>Physician's Visits</b>, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.</p>	80% of PA	80% of U&C
<p><b>Physiotherapy</b>, physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.</p>	80% of PA	80% of U&C
<p><b>Medical Emergency Expenses</b>, 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. <i>(The Copay/per visit Deductible will be waived if admitted to the Hospital.) (The \$100 Copay/per visit Deductible is in addition to the Policy Deductible.)</i></p>	80% of PA / \$100 Copay per visit	80% of U&C / \$100 Deductible per visit
<p><b>Diagnostic X-ray Services</b></p>	80% of PA	80% of U&C
<p><b>Radiation Therapy</b></p>	80% of PA	80% of U&C
<p><b>Chemotherapy</b></p>	80% of PA	80% of U&C
<p><b>Laboratory Services</b></p>	80% of PA	80% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
<b>Tests &amp; Procedures</b> , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	80% of U&C
<b>Injections</b> , when administered in the Physician's office and charged on the Physician's statement.	80% of PA	80% of U&C
<b>Prescription Drugs</b> , <i>(Prescription Drugs dispensed at the Student Health Center are payable at 100% and are not subject to the Copays. Self-Injectables are not covered.)</i>	UnitedHealthcare Pharmacy (UHCP) \$10 Copay per prescription for Tier 1 \$20 Copay per prescription for Tier 2 40% Coinsurance 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)	80% of Usual and Customary Charges up to a 31-day supply per prescription
OTHER		
<b>Ambulance Services</b>	80% of PA	80% of U&C
<b>Durable Medical Equipment</b>	No Benefits	
<b>Consultant Physician Fees</b> , when requested and approved by attending Physician.	80% of PA	80% of U&C
<b>Dental Treatment</b> , made necessary by Injury to Sound, Natural Teeth only. <i>(\$1,000 maximum Per Policy Year) (Benefits are not subject to the \$500,000 Maximum Benefit.)</i>	80% of PA	80% of U&C
<b>Dental Treatment</b> , benefits paid for removal of abscessed or impacted wisdom teeth only.	80% of PA	80% of U&C
<b>Acupuncture</b> , <i>(Acupuncture benefits are not subject to the \$500,000 Maximum Benefit.) (Payable only when referred by the Student Health Center.)</i>	80% of PA	80% of U&C

OTHER	Preferred Providers	Out-of-Network Providers
<p><b>Reconstructive Breast Surgery Following Mastectomy</b>, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.</p>	Paid as any other Sickness	
<p><b>Diabetes Services</b>, same as any other Sickness in connection with the treatment of diabetes. <i>(See Benefits for Treatment of Diabetes and Benefits for Diabetes Outpatient Self-Management.)</i></p>	Paid as any other Sickness	
<p><b>Mental Illness Treatment</b>, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.</p>	Paid as any other Sickness	
<p><b>Substance Use Disorder Treatment</b>, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.</p>	Paid as any other Sickness	
<p><b>Maternity</b>, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.</p>	Paid as any other Sickness	
<p><b>Complications of Pregnancy</b></p>	Paid as any other Sickness	
<p><b>Elective Abortion</b>, <i>(\$500 maximum Per Policy Year) (Elective Abortion benefits are not subject to the \$500,000 Maximum Benefit.)</i></p>	Paid as any other Sickness	

OTHER	Preferred Providers	Out-of-Network Providers
<p><b>Preventive Care Services</b>, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the <i>United States Preventive Services Task Force</i>; 2) immunizations that have in effect a recommendation from the <i>Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</i>; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>.</p> <p>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.</p>	100% of PA	No Benefits

## **Preferred Provider Information**

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"**Preferred Providers**" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

### **UnitedHealthcare Options PPO.**

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-344-5989 and/or by asking the provider when making an appointment for services.

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

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

"**Network Area**" means the 50 mile radius around the local school campus the Named Insured is attending.

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

### **Inpatient Expenses**

**PREFERRED PROVIDERS** - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities. Call (888) 344-5989 for information about Preferred Hospitals.

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

### **Outpatient Hospital Expenses**

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

### **Professional & Other Expenses**

Benefits for Covered Medical Expenses provided by UnitedHealthcare Options PPO will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

## UnitedHealthcare Pharmacy Benefits

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

You are responsible for paying the applicable Copayments and/or Coinsurance. Your Copayments and/or Coinsurance is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access [www.uhcsr.com](http://www.uhcsr.com) or call 1-855-828-7716 for the most up-to-date tier status.

\$10 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.  
\$20 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.  
40% Coinsurance per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

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 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](http://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 are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- 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](http://www.uhcsr.com) or call Customer Service at 1-855-828-7716.

## Maternity Testing

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

### Initial screening at first visit:

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

**Each visit:** Urine analysis

**Once every trimester:** Hematocrit and Hemoglobin

**Once during first trimester:** Ultrasound

**Once during second trimester:**

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

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

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

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

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-888-344-5989.

## Accidental Death and Dismemberment Benefits

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### 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	\$ 7,500
Two or More Members	\$ 7,500
One Member	\$ 1,000

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

### Excess Provision

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Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, this Excess Provision will not be applied to the first \$100 of medical expenses incurred.

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

**Important:** The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

### Continuation Privilege

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All Insured Persons who have been continuously insured under the school's regular student Policy for at least 6 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

Application must be made and premium must be paid directly to UnitedHealthcare **StudentResources** and be received within 14 days after the expiration date of your student coverage. For further information on the Continuation privilege, please contact UnitedHealthcare **StudentResources**.



## **Mandated Benefits**

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### ***Benefits for Prostate Cancer Screening***

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening by taking prostate antigen blood test. "Prostate cancer screening tests" includes a prostate antigen blood test or another test that is equivalent or better in cancer detection when performed by or recommended by a Physician.

Benefits are for men who are Insureds and are at least 35 years of age but less than 40 years of age and that are in a high risk group. "High risk" group means a person who is African-American or who has a family history of prostate cancer. Benefits are provided on an annual basis for men 40 years of age or more.

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

### ***Benefits for Mammography***

Benefits will be paid the same as any other Sickness for screening mammography to identify breast cancer if the Policy covers mastectomies and prosthetic devices and reconstructive surgery incident to mastectomies according to the following guidelines:

1. A baseline mammogram for women age 35 to age 39;
2. One mammogram every two years for women age 40 to 49 every 2 years, or more frequently if recommended by a physician; and
3. An annual mammogram for women age 50 and over;
4. A mammogram at any age for a covered Insured with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by a Physician.

"Low-dose Mammography Screening" and "Mammogram" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure to deliver less than one rad mid-breast, with two views for each breast.

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

### ***Benefits for Cervical Cancer Screening***

Benefits will be paid the same as any other Sickness for the cost of cervical cancer screening test commonly known as a "pap smear". Benefits will be provided for an annual pap smear cancer screening test for an Insured Person who is 18 or more years of age.

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

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

Benefits will be paid the same as any other Sickness for the formulas necessary for the treatment of Phenylketonuria, when under the supervision of a Physician and are special dietary formulas which are medically necessary for the therapeutic treatment of Phenylketonuria.

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

### ***Benefits for Treatment of Diabetes***

Benefits will be paid the same as any other prescription or pharmacy services for the treatment of Diabetes. Benefits shall include medication, equipment, and supplies when prescribed by a Physician.

"Diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes.

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

### ***Benefits for Diabetes Outpatient Self-Management***

Benefits will be paid the same as any other Sickness for outpatient self-management training or education and medical nutrition therapy for the treatment of diabetes if Diabetes treatment is prescribed by a Physician. Diabetes outpatient self-management training or education and medical nutrition therapy must be provided by a Physician with training in the treatment of Diabetes.

"Diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes.

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

### ***Benefits for Colorectal Cancer Screening***

Benefits will be paid the same as any other Sickness for colorectal cancer screening examinations and laboratory tests for an asymptomatic Insured Person in accordance with and at the frequency identified in the current American Cancer Society guidelines for colorectal cancer screenings.

Benefits apply to an Insured Person who is: a) at least 50 years of age; or b) less than 50 years and at high risk for colorectal cancer. For Insured Persons considered at high risk, screenings shall be provided at a frequency determined necessary by a Physician. An Insured Person is considered at high risk for colorectal cancer because of:

- 1) family history;
- 2) prior experience of cancer or precursor neoplastic polyps;
- 3) a history of a chronic digestive disease condition, including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis;
- 4) the presence of any appropriate recognized gene markers for colorectal cancer; or
- 5) other predisposing factors.

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

### ***Benefits for Newborn Infant Hearing Screening***

Benefits will be paid the same as any other Sickness for a Newborn Infant hearing screening to be performed within 30 days after the Newborn Infant's birth. If the initial screening determines that the child may have a hearing impairment, benefits shall also include a confirmatory hearing diagnostic evaluation.

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

### ***Benefits for Well-Baby Exams***

Benefits will be paid the same as any other Sickness for routine Well-baby Exams performed by a qualified Health Care Professional for a Dependent child.

“Well-baby Exams” means (a) a periodic physical examination by a qualified Health Care Professional of a baby during the first 24 months of life in which information is collected on matters including normal development, growth rate, hearing, vision, language skills, motor development, diet, general care, preventative health care, immunizations, and infectious diseases and; (b) consultation between the Health Care Professional and a parent.

“Health Care Professional” means a health aide, physician, nurse, and physician assistant, but does not include a practitioner of religious healing.

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

### ***Benefits for Routine Care Costs for Cancer Clinical Trials***

Benefits will be paid the same as any other Sickness for Insured's routine care costs associated with an approved cancer clinical trial. The Insured's treating Physician must determine:

- 1) there is no superior non-investigational treatment alternative; and
- 2) available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any non-investigational alternative.

Benefits for routine care costs include:

- 1) prevention, diagnosis, treatment, and palliative care of cancer;
- 2) medical care for an Approved Clinical Trial related to cancer that would otherwise be covered under the plan if the medical care were not in connection with an Approved Clinical Trial related to cancer;
- 3) items or services necessary to provide an investigational item or service;
- 4) the diagnosis or treatment of complications;
- 5) a drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device;
- 6) services necessary to administer a drug or device under evaluation in the clinical trial; and
- 7) transportation for the Insured that is primarily for and essential to medical care.

Benefits for routine care costs do not include:

- 1) a drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration;
- 2) housing, companion expenses, or other nonclinical expenses associated with the clinical trial;
- 3) an item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the Insured;
- 4) an item or service excluded from coverage under the plan; and
- 5) an item or service paid for or customarily paid for through grants or other funding.

“Approved Clinical Trials” means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care of a subject, if the study is approved by:

1. an institutional review board; and
2. one of the following:
  - a. the United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers;
  - b. the United States Department of Health and Human Services, United States Food and Drug Administration;
  - c. the United States Department of Defense;
  - d. the United States Department of Veterans Affairs; or
  - e. a nongovernmental research entity abiding by current National Institutes of Health guidelines.

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

## **Definitions**

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

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

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

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

**DEDUCTIBLE** means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

**DOMESTIC PARTNER** means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

**INJURY** means bodily injury which is all of the following:

- 1) directly and independently caused by specific accidental contact with another body or object.
- 2) unrelated to any pathological, functional, or structural disorder.
- 3) a source of loss.
- 4) treated by a Physician within 30 days after the date of accident.
- 5) sustained while the Insured Person is covered under this policy.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

**INPATIENT** means an uninterrupted confinement that follows formal admission to a Hospital by reason of an Injury or Sickness for which benefits are payable under this policy.

**MEDICAL EMERGENCY** means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

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

- 1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury.
- 2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury.
- 3) In accordance with the standards of good medical practice.
- 4) Not primarily for the convenience of the Insured, or the Insured's Physician.
- 5) The most appropriate supply or level of service which can safely be provided to the Insured.

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

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

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

**PRE-EXISTING CONDITION** means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

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

**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. Usual and Customary Charges will be calculated at the 80th percentile. No payment will be made under this policy for any expenses incurred which are in excess of Usual and Customary Charges. The Insured person is responsible for any amount billed for a health care service or supply item that exceeds the amount of final payment.

## **Exclusions and Limitations**

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

1. Acne;
2. Allergy, including allergy testing;
3. Addiction, such as: caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
4. Learning disabilities;
5. Biofeedback;
6. Durable Medical Equipment;
7. Circumcision;
8. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
9. 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;
10. Dental treatment, except as specifically provided in the Schedule of Benefits;
11. Elective Surgery or Elective Treatment;
12. Eye examinations, except as specifically provided in the Benefits for Well-baby Exams, 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. Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery);
14. Hearing examinations, except as specifically provided in the Benefits for Newborn Infant Hearing Screening; hearing aids; or cochlear implants; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
15. Hirsutism; alopecia;
16. 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;
17. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
18. Injury sustained while (a) participating in any interscholastic, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
19. Organ transplants, including organ donation;
20. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
21. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;
22. Prescription Drugs, services or supplies as follows:
  - a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;

- b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
  - c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
  - d) Products used for cosmetic purposes;
  - e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
  - f) Anorectics - drugs used for the purpose of weight control;
  - g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
  - h) Growth hormones; or
  - i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
23. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
  24. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
  25. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
  26. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
  27. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except treatment of a covered Injury or treatment of chronic purulent sinusitis;
  28. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping;
  29. Sleep disorders;
  30. Supplies, except as specifically provided in the policy;
  31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy;
  32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
  33. 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
  34. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

## **FrontierMEDEX: Global Emergency Services**

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

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

Domestic Students, insured spouse/Domestic Partner and insured minor child(ren): You are eligible for FrontierMEDEX services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

FrontierMEDEX includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment.

### **Key Services include:**

- \*Transfer of Insurance Information to Medical Providers
- \*Transfer of Medical Records
- \*Worldwide Medical and Dental Referrals
- \*Emergency Medical Evacuation
- \*Transportation to Join a Hospitalized Participant
- \*Replacement of Corrective Lenses and Medical Devices
- \*Hotel Arrangements for Convalescence
- \*Return of Dependent Children
- \*Legal Referrals
- \*Message Transmittals
- \*Monitoring of Treatment
- \*Medication, Vaccine and Blood Transfers
- \*Dispatch of Doctors/Specialists
- \*Facilitation of Admission Hospital Payments
- \*Transportation After Stabilization
- \*Continuous Updates to Family and and Home Physician
- \*Emergency Travel Arrangements
- \*Replacement of Lost or Stolen Travel Documents
- \*Repatriation of Mortal Remains
- \*Transfer of Funds
- \*Translation Services

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

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

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



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

## **Notice of Appeal Rights**

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### **Right to Internal Appeal**

#### **Standard Internal Appeal**

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

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at 888-344-5989 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **StudentResources**, 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 gain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact Claims Appeals at 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **StudentResources**, 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 of care, or effectiveness.

#### **Standard External Review**

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

## **Expedited External Review**

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

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

## **Standard Experimental or Investigational External Review**

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

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

## **Expedited Experimental or Investigational External Review**

An Insured Person, or an Insured Person's Authorized Representative, may submit an oral request for an Expedited Experimental or Investigational External Review when:

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
  - a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
  - b. Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly; or
2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and
  - a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
  - b. The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly.

## Where to Send External Review Requests

All types of External Review requests shall be submitted to Claims Appeals at the following address:

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

## Questions Regarding Appeal Rights

Contact Customer Service 888-344-5989 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

## Online Access to Account Information

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UnitedHealthcare **StudentResources** Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to **My Account** at [www.uhcsr.com/myaccount](http://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 **StudentResources**' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

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

## UnitedHealth Allies

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

## ID Cards

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

## Collegiate Assistance Program

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

## **Claim Procedure**

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In the event of Injury or Sickness, students should:

- 1) Report to the Student Health Service for treatment, 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 university under which the student is insured. A Company claim form is not required for filing a claim.
- 3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

### **The Plan is Underwritten by**

UnitedHealthcare Insurance Company

### **Submit all Claims or Inquiries to:**

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-800-767-0700

customerservice@uhcsr.com

claims@uhcsr.com

### **Sales/Marketing Services:**

UnitedHealthcare **Student**Resources

805 Executive Center Drive West, Suite 220

St. Petersburg, FL 33702

1-800-237-0903

E-Mail: info@uhcsr.com

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

**This Brochure is based on Policy #'s**

**2013-335-2**

University of Alaska Fairbanks  
Student Health & Counseling Center  
P.O. Box 755580  
Fairbanks, AK 99775-5580  
phone 907-474-7043 fax 907-474-5777

**2013-248-2**

University of Alaska Anchorage  
Student Health & Counseling Center  
3211 Providence Drive, RH 120  
Anchorage, AK 99508  
907-786-4040

**2013-248-2**

University of Alaska Southeast  
Student Services  
11120 Glacier Highway  
Juneau, AK 99801  
877-465-4827

UAF, UAA & UAS are affirmative action/equal opportunity  
employer and educational institutions.







UAF



UAA





**POLICY NUMBER: 2013-248-2/335-2**

**NOTICE:**

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

**NOC #1 - 9/17/13**

1. Corrected the fourth paragraph on the SOB Header to read: Usual and Customary Charges are based on data provided by FAIR Health, Inc. using the 80th percentile based on location of the Policyholder.
2. Corrected Usual and Customary Charges definition on page 17:  
From: 2) made to persons having similar medical conditions in the locality where services are rendered.  
To: 2) made to persons having similar medical conditions in the locality of the Policyholder.