2013-2014

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

PURDUE
UNIVERSITY

West Lafayette, Indiana

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

UnitedHealthcare®
A UnitedHealth Group Company

12-BR-IN

13-261-1

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 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-888-224-4754. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-888-224-4754 or by visiting us at www.uhcsr.com/purdue.

Eligibility

All registered domestic students taking six or more credit hours or co-op students who are degree seeking are eligible to enroll in this insurance Plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse or same-sex Domestic Partner and Dependent children under 26 years of age. An insured student may cover a newly acquired Dependent by completing the enrollment form and paying any premium due within 30 days of marriage, birth or other acquisition of a Dependent. 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.

This plan is not an employer/employee plan or a group plan and is not meant to be a fully comprehensive plan. It is a blanket student plan and contains limited benefits.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 6, 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 5, 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.

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.

Purdue University Student Health Center www.purdue.edu/PUSH

The Purdue University Student Health Center (PUSH) provides outpatient care, excluding maternity (labs are available) and pediatric services, for Purdue University students and their spouses. Dependents are not eligible to receive Psychotherapy services at PUSH.

The Student Insurance Plan supplements the medical benefits provided by the Student Health Fee while at the Student Health Center, and also provides coverage in the local medical community and when away from campus.

Procedure for Seeking Medical Treatment

When on campus, if an Insured has an Injury or Sickness of a non-emergency nature (i.e., not life-threatening) he/she should use the Purdue University Student Health Center (PUSH) as the initial contact. Services rendered at PUSH are subject to a $15 co-pay. PUSH services available to full-time students at no charge are not subject to the $15 co-pay. A $200 Deductible for Preferred Providers and a $400 Deductible for Out-of-Network Providers will apply to all services outside PUSH with the following exception: if PUSH is closed and you are seeking treatment for a medical emergency (as defined by the Policy). For Medical Emergencies there is a $50 Copay for Preferred Providers or a $50 Deductible for Out-of-Network Providers (this Copay/deductible is in lieu of the Policy Deductible).

When seeking treatment outside of PUSH, students are encouraged by the University to utilize services provided by the UnitedHealthcare Choice Plus network of providers. The UnitedHealthcare Choice Plus network is available and may provide savings to insured students. To find out if there are hospitals or health care providers in your area who are part of the network, call the Company at 1-888-224-4754 or visit the website at www.uhcsr.com/Purdue.

Preventive Care

Preventive Care Services are available at PUSH as well as Preferred Providers. Please see the Schedule of Benefits for additional information.

Purdue Pharmacy and Prescription Drug Information

The Purdue University pharmacy is the preferred pharmacy of the Domestic Student Plan. Insured students and their insured dependents can have prescriptions filled at the pharmacy located in the RHPH building Room 118.

A $10 Copay for generic and $20 Copay for brand name applies to each covered prescription filled at the Purdue Pharmacy. When the Purdue Pharmacy is used, the plan will pay 100% above the $10 generic and $20 brand name Copay. When you do not use the Purdue Pharmacy, prescriptions must be filled at a UnitedHealthcare Network pharmacy.

Pre-natal Vitamins

Pre-natal vitamins are available at Purdue University Pharmacy. For additional information regarding Maternity Testing, please call the Company at 1-888-224-4754.

Pediatric Care

Pediatric Care is not provided at PUSH.

Benefits for Diabetes

Insulin pumps/supplies and glucometers are not available at the Purdue University Pharmacy. Please contact PUSH Student Insurance Office for more information.

Benefits for Mental Illness

Benefits will be paid the same as any other Sickness for the treatment of Mental Illness. Dependents are not eligible to receive Mental Illness Treatment services at PUSH.

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

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 the 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 (Per Insured Person) (Per Policy Year)

Deductible Preferred Provider: $200 (Per Insured Person) (Per Policy Year)
Deductible Out-of-Network: $400 (Per Insured Person) (Per Policy Year)
Deductible Out-of-Network: $400 (For all Insureds in a Family) (Per Policy Year)

Coinsurance Preferred Provider: 90% except as noted below

Coinsurance Out-of-Network: 70% except as noted below

Coinsurance Out-of-Pocket Maximum Preferred Providers: $1,500 (Per Insured Person, Per Policy Year)

Coinsurance Out-of-Pocket Maximum Preferred Providers: $3,500 (For all Insured in a Family, Per Policy Year)

Coinsurance Out-of-Pocket Maximum Out of Network: $3,000 (Per Insured Person, Per Policy Year)

Coinsurance Out-of-Pocket Maximum Out of Network: $7,000 (For all Insured in a Family, Per Policy Year)

The Preferred Providers 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.

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.

Purdue Student Health Center Benefits: The Deductible will be waived when treatment is rendered at the Purdue Student Health Center (PUSH) or for Medical Emergency when the PUSH is closed and Dependent children. University mandated vaccinations will be payable when services are rendered at PUSH. Prenatal vitamins are covered at PUSH following a Copay of $15.

The Co-payments for PUSH services are $15 per visit. However, the Co-payments for PUSH services and Prescription Drugs do not apply toward the Deductible or Coinsurance provision.

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

Usual and Customary is based on FAIR Health, Inc. at the 75th percentile.

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

PA = Preferred Allowance	U&C = Usual & Customary Charges	
INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Room and Board Expense, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	90% of PA	70% of U&C
Intensive Care	Paid under Room and Board Expenses	
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.	90% of PA	70% of U&C
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
Physiotherapy	Paid under Hospital Miscellaneous	
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.	90% of PA	70% of U&C
Assistant Surgeon	No Benefits	
Anesthetist, professional services administered in connection with Inpatient surgery.	90% of PA	70% of U&C
Registered Nurse's Services, private duty nursing care.	No Benefits	
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	90% of PA	70% of U&C
Pre-Admission Testing, payable within 5 working days prior to admission.	Paid under Hospital Miscellaneous	

OUTPATIENT	Preferred Providers	Out-of-Network Providers
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.	90% of PA	70% 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.	90% of PA	70% of U&C
Assistant Surgeon	No Benefits	
Anesthetist, professional services administered in connection with outpatient surgery.	90% of PA	70% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	90% of PA	70% of U&C
Physiotherapy, Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, 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.	90% of PA	70% of U&C
Medical Emergency Expenses, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. (The Copay/per visit Deductible is in lieu of the Policy Deductible.)	90% of PA $50 Copay per visit	90% of U&C $50 Deductible per visit
Diagnostic X-ray Services	90% of PA	70% of U&C
Radiation Therapy	90% of PA	70% of U&C
Chemotherapy	90% of PA	70% of U&C
Laboratory Services	90% of PA	70% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
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. *A Quantifieron Gold TB test will be covered when administered at PUSH.*	90% of PA	70% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	90% of PA	70% of U&C
Prescription Drugs, includes Acne and Allergy medications, and prenatal vitamins. Prescriptions filled at Purdue Pharmacy, the plan will pay 100% above the following Copays: ◆ $10 Copay for generic; ◆ $20 Copay for brand name; If you do not use the Purdue Pharmacy, prescriptions must be filled at a UnitedHealthcare Pharmacy (up to a 31 day supply per prescription). Copay greater of: ◆ $20 Copay for Tier 1 prescriptions; ◆ $40 Copay for Tier 2 prescriptions; or ◆ 30% Coinsurance up to a $1,000 Coinsurance Out-of-Pocket maximum. After the $1,000 maximum: Copay greater of: ◆ $20 Copay for Tier 1 prescriptions; ◆ $40 Copay for Tier 2 prescriptions; or ◆ 10% Coinsurance Mail order Prescription Drugs through UnitedHealthcare Pharmacy at 2 times the retail Copay up to a 90 day supply.		No Benefits
OTHER	**Preferred Providers**	**Out-of-Network Providers**
Ambulance Services	90% of U&C	90% of U&C
Durable Medical Equipment	No Benefits	
Consultant Physician Fees, when requested and approved by attending Physician.	90% of PA	70% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *(Benefits are not subject to the $500,000 Maximum Benefit.)*	90% of U&C	90% of U&C

OTHER	Preferred Providers	Out-of-Network Providers
Mental Illness Treatment, services received on an Inpatient and outpatient basis.	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis.	Paid as any other Sickness	
Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	No Benefits	
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

OTHER	Preferred Providers	Out-of-Network Providers
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy. *See Benefits for Reconstructive Surgery and Prosthetic Device.*	Paid as any other Sickness	
Diabetes Services, in connection with the treatment of diabetes. *See Diabetes Benefit.*	Paid as any other Sickness	
Smoking Cessation	Paid as any other Sickness	
Sexual Reassignment Treatement, *(Includes hormone replacement and treatment, and counseling. Sexual Reassignment Surgery is excluded.)*	Paid as any other Sickness	

UnitedHealthcare Pharmacy Benefits

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

You are responsible for paying the applicable Copayments and/or Coinsurance. Your Copayment/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 or call 1-855-828-7716 for the most up-to-date tier status.

Copays per prescription order or refill:

The greater of $20 for Tier 1; $40 for Tier 2; or 30% Coinsurance up to a 31-day supply.

Out-of pocket maximum:

After the Insured has paid $1,000 in out-of-pocket expenses for Prescription Drugs, then the greater of $20 for Tier 1; $40 for Tier 2; or 10% Coinsurance per prescription order or refill up to a 31-day supply.

Mail order Prescription Drugs are available at 2 times the retail Copay up to a 90 day supply.

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

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 please visit www.uhcsr.com and log in to your on-line account, or call 1-855-828-7716.

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-2.
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

Definitions

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 at 1-855-828-7716.

Preferred Provider Information

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in your local school area and nationally are: Hospitals and Physicians participating in the UnitedHealthcare Choice Plus Network.

The availability of specific providers is subject to change without notice. Insured's should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-224-4754, 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. Insured's may incur significant 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 Hospital 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. Call 1-888-224-4754 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 providers will be paid at the Coinsurance percentages specified in the Schedule of Benefits, or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Maternity Testing

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

Initial screening at first visit:

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

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

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

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

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

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are covered at PUSH only. For additional information regarding Maternity Testing, please call the Company at 1-888-224-4754.

Accidental Death Benefit

If an accidental Injury should independently of all other causes and within 180 days from the date of Injury solely result in the loss of the Insured's life, the Insured's beneficiary may request the Company to pay $25,000 in addtion to payment under any Medical Expense Benefit provisions.

Continuation Privilege

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 **Student**Resources and be received within 14 days after the expiration date of your student coverage. For further information on the Continuation privilege, please contact UnitedHealthcare **Student**Resources at 1-888-224-4754 or PUSH Student Insurance office.

Monthly Continuation Rates

Student Only	$ 267.00
Spouse	$1,012.00
Each Child	$ 339.00

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

Coordination of Benefits Provision

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

Mandated Benefits

Benefits for Pervasive Developmental Disorder

Benefits will be provided in accordance with a Physician's treatment plan for pervasive developmental disorder. Services will be provided without interruption, as long as those services are consistent with the treatment plan and with Medical Necessity decisions. As used in this benefit, "Pervasive Developmental Disorder" means a neurological condition including Asperger's Syndrome and Autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, and lifetime maximums, but any other exclusions and limitations within the policy that are inconsistent with the treatment do not apply.

Diabetes Benefit

Benefits will be paid the same as any other Sickness for the Medically Necessary treatment of Diabetes including the equipment and supplies for the treatment of Insulin-using, Non-insulin using diabetics, or elevated blood glucose levels induced by pregnancy or other medical conditions, when recommended or prescribed by a Physician.

Benefits will also be provided for self-management training for one or more visits after receiving a diagnosis of Diabetes by a Physician, or a diagnosis that represents a significant change in the Insured's symptoms or condition and makes changes in the Insured's self-management Medically Necessary. Benefits will be provided for one or more visits for reeducation or refresher training.

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

Benefits for Reconstructive Surgery and Prosthetic Device

Benefits will be paid the same as any other Sickness for prosthetic devices and reconstructive surgery incident to a mastectomy. Surgery benefits shall include all stages of reconstruction of the breast on which the mastectomy has been performed and surgical reconstruction of the other breast to produce symmetry if recommended by a Physician.

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

Benefits for Breast Cancer Screening

Benefits will be paid the same as any other Sickness for breast cancer screening mammography performed on dedicated equipment for diagnostic purposes on referral by a Physician according to the following guidelines:

1. One baseline mammogram for an Insured at least thirty-five but less than forty years of age, or more often if recommended by a Physician; or
2. One mammogram every year for an Insured who is less than forty years of age, and considered a woman at risk.

   A woman at risk is defined as a woman who meets at least one of the following descriptions:
   - A woman who has a personal history of breast cancer.
   - A woman who has a personal history of breast disease that was proven benign by biopsy.
   - A woman whose mother, sister, or daughter has had breast cancer.
   - A woman who is at least thirty (30) years of age and has not given birth.
3. One mammogram every year for an Insured at least forty years of age.
4. Any additional mammography views that are required for proper evaluation.
5. Ultrasound services, if determined Medically Necessary by the Physician treating the Insured.

This benefit is in addition to any other benefits specifically provided for x-rays, laboratory testing, or Sickness examinations.

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

Benefits for Cancer Clinical Trials

Benefits will be paid the same as any other Sickness for Routine Care Costs that are incurred in the course of a Clinical Trial if the policy would provide benefits for the same Routine Care Costs not incurred in a Clinical Trial.

"Routine Care Cost" means the cost of Medically Necessary services related to the Care Method that is under evaluation in a Clinical Trial. It does not include:

1. Health care service, item, or investigational drug that is the subject of the Clinical Trial.
2. Any treatment modality that is not part of the Usual and Customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the Clinical Trial.
3. Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
4. An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
5. Transportation, lodging, food, or other expenses for the Insured or a family member or companion of the Insured that are associated with travel to or from a facility where a Clinical Trial is conducted.

6. A service, item, or drug that is provided by a Clinical Trial sponsor free of charge for any new patient.
7. A service, item, or drug that is eligible for reimbursement from a source other than an Insured's individual contract or group contract, including the sponsor of the Clinical Trial.

"Clinical Trial" means a Phase I, II, III, or IV research study:

1. That is conducted:
   (A) using a particular Care Method to prevent, diagnose, or treat a cancer for which: (i) there is no clearly superior, noninvestigational alternative Care Method; and (ii) available clinical or preclinical data provides a reasonable basis from which to believe that the Care Method used in the research study is at least as effective as any noninvestigational alternative Care Method;
   (B) in a facility where personnel providing the Care Method to be followed in the research study have: (i) received training in providing the Care Method; (ii) expertise in providing the type of care required for the research study; and (iii) experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and
   (C) to scientifically determine the best Care Method to prevent, diagnose, or treat the cancer; and
2. That is approved or funded by one of the following:
   (A) A National Institutes of Health institute;
   (B) A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center;
   (C) The federal Food and Drug Administration;
   (D) The United States Department of Veterans Affairs;
   (E) The United States Department of Defense;
   (F) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103; or
   (G) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

"Care Method" means the use of a particular drug or device in a particular manner.

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

Definitions

COINSURANCE 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% Coinsurance for the remainder of the Policy Year according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Coinsurance 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.

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; and 4) is the same-sex as the Named Insured. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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. 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.

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.

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.

MENTAL ILLNESS means a psychiatric disorder that substantially disturbs an individual's thinking, feeling, or behavior and impairs the individual's ability to function and is listed in the mental health or psychiatric diagnostic categories in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

SICKNESS means sickness or disease of the Insured Person which causes loss 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. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions and Limitations

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

1. Acupuncture;
2. Assistant Surgeon Fees;
3. Learning disabilities;
4. Biofeedback;
5. Durable Medical Equipment;
6. Circumcision;
7. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
8. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery or Elective Treatment;
11. Elective Abortion;
12. Eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, 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; hearing aids; or other treatment for hearing defects and problems, except as a result of an infrection 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, 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; or fighting;

21. 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;
22. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures; except as specifically provided in the policy;
23. 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;
24. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
25. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery, except for treatment of a covered Injury; This exclusion does not apply to newborns;
26. 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 or while taking flight instructions for University credit;
27. Sleep disorders;
28. Supplies, except as specifically provided in the policy;
29. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
30. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
31. 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
32. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

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

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at 1-888-224-4754 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

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

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

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

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

Right to External Independent Review

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

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

Standard External Review

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

Expedited External Review

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

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
   a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
   b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function;

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

Where to Send External Review Requests

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

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

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 access number indicated on your 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 or same sex Domestic Partner and minor child(ren) are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

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

Domestic Students, insured spouse or same sex 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
*Emergency Travel Arrangements and Home Physician
*Replacement of Lost or Stolen Travel Documents
*Repatriation of Mortal Remains
*Transfer of Funds
*Translation Services

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

To access services please call:

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

(410) 453-6330 Collect outside the United States

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

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

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

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

Online Access to Account Information

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

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

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

ID Cards

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

UnitedHealth Allies

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

Claim Procedure

In the event of Injury or Sickness, the students should:

1) Report to the Purdue University Student Health Center for treatment or referral, or when not in school, to your 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, student identification 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 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 Customer Service Inquiries to:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-888-224-4754 (dedicated Purdue line)
1-800-767-0700
customerservice@uhcsr.com
claims@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 # 2013-261-1 v3

PUSH Contact Information and Hours

There are representatives at PUSH (Room 338 and 340) to assist you with your student health insurance needs, and to answer questions about enrollment, policy benefits and claims.

Office Phone:	(765) 496-3998
Fax:	(765) 496-2524
Email:	student-insurance@purdue.edu

Office Hours

Monday through Thursday	8:30 - 4:30
Friday	9:30 - 4:30

During Summer Semester and Academic breaks, PUSH is closed from 12 - 1:00PM

Office Hours - Subject to Change.

Please visit the PUSH website: www.purdue.edu/push to confirm the current hours of operation.