**READ YOUR CERTIFICATE CAREFULLY**

# 2013-2014

# Student Injury and Sickness Insurance Plan

**PLEASE NOTE:**

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

## NON-RENEWABLE ONE YEAR TERM INSURANCE

## Blanket Accident and Health Policy

## DESIGNED ESPECIALLY FOR THE NORTH CAROLINA STUDENTS OF

DeVry University

**Important:**

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

### PRE-EXISTING CONDITION EXCLUSION

Conditions diagnosed, treated or recommended for treatment within the 12 months prior to the Insured's effective date under the policy may not be covered immediately. This exclusion will not be applied to an Insured Person who is under Age 19.

UnitedHealthcare
A UnitedHealth Group Company

## Notice
## Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $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 1-866-808-8298. 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.

Dear Students and Parents:

Recognizing the expense associated with having insurance today and keeping the interest and protection of all our students in mind, DeVry University has arranged for an injury and sickness insurance program for students. All U.S. full-time onsite students are required to enroll in this injury and sickness insurance Plan, unless you have your own health policy or are covered as a dependent on a parent's or spouse's policy.

Please read this Certificate of Coverage carefully for current cost, coverage and benefits. Although benefits of the Plan are limited in certain areas, it is designed to help alleviate the basic cost of hospital and some outpatient care resulting from an injury or illness. This Plan also provides the option for spouse and/or children coverage. Special provider arrangements have been negotiated with the UnitedHealthcare network of hospitals which may reduce your out-of-pocket expenses for hospital services. Students may apply for the insurance program at registration. Only the student portion of the premium may be charged to the student's DeVry University account.

Although health insurance coverage is a condition of enrollment at DeVry University, a student may complete a waiver form at registration if they already have their own health policy or are covered as a dependent on a parent's or spouse's policy.

DeVry University sincerely believes that this insurance program will help reduce the cost of treatment for sickness and injury from accidents that may occur. Should you wish for more detailed information about the plan, please contact Student Central at the location you will be attending.

Sincerely,

Madeleine Slutsky
DeVry University
VP of Student and Career Services

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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 1-866-808-8298 or by visiting us at www.uhcsr.com/devry.

## Eligibility

All registered full-time students are required to enroll in this insurance Plan at registration, unless proof of comparable coverage is furnished.

All registered part-time students taking at least 6 credit hours and all registered graduate students taking credit hours 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 and correspondence courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse and dependent children under 26 years of age. Dependent eligibility expires concurrently with that of the Insured student.

Dependent coverage must be applied for by filling out the Insurance Enrollment Card and by paying the required premium.

## Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., July 8, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., July 7, 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.

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

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

The Policy is a Non-Renewable One Year Term Policy. It is the Insured's responsibility to obtain coverage the following year in order to maintain continuity of coverage.

## Premium Rates

| | Annual |
|---|---|
| Student - Under Age 30 | $ 754 |
| Student - Age 30 to 39 | $ 943 |
| Student - Age 40 to 49 | $ 1,409 |
| Student - 50 and Older | $ 2,083 |
| Spouse | $ 2,714 |
| All Children | $ 1,886 |

*Note: The amounts stated above include certain fees, which include amounts that are paid to certain non-insurer vendors or consultants by, or at the direction of your school.*

Additional coverage periods are available for onsite full-time students at https://studentcenter.uhcsr.com/devry.

Additional coverage periods for all other students are available at https://www.uhcsr.com/devry.

## 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.

## Schedule of Medical Expense Benefits

**Injury and Sickness**

**Maximum Benefit: $500,000 Paid As Specified Below (Per Insured Person, Per Policy Year)**

**Deductible: $5,000 (Per Insured Person, Per Policy Year)**

**(The Deductible will not be applied until the Company has paid $2,500 in Covered Medical Expenses.)**

**Coinsurance Preferred Provider: 80% to $2,500, Deductible applies after $2,500, then 100% thereafter**

**Coinsurance Out-of-Network Provider: 50% to $2,500, Deductible applies after $2,500, then 50% thereafter**

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

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

The Company will pay Covered Medical Expenses incurred at 80% for Preferred Providers and 50% for Out-of-Network Providers up to $2,500 before the Insured Person is responsible for satisfaction of the $5,000 Deductible. After the Company pays $2,500, the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at 100% for Preferred Providers and 50% for Out-of-Network Providers not to exceed the Maximum Benefit of $500,000.

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. | 80% of PA | 50% of U&C |
| **Intensive Care** | 80% of PA | 50% of U&C |

| INPATIENT | Preferred Providers | Out-of-Network Providers |
|---|---|---|
| **Hospital Miscellaneous Expense,** such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. | 80% of PA | 50% of U&C |
| **Routine Newborn Care,** while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier. | Paid as any other Sickness | |
| **Physiotherapy** | 80% of PA | 50% of U&C |
| **Surgeon's Fees,** if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | 80% of PA | 50% of U&C |
| **Assistant Surgeon** | 50% of PA | 50% of U&C |
| **Anesthetist,** professional services in connection with inpatient surgery. | 80% of PA | 50% of U&C |
| **Registered Nurse's Services,** private duty nursing care. | 80% of PA | 50% of U&C |
| **Physician's Visits,** non-surgical services when confined as an Inpatient. | 80% of PA | 50% of U&C |
| **Pre-Admission Testing,** payable within 3 working days prior to admission. | 80% of PA | 50% of U&C |
| **OUTPATIENT** | | |
| **Surgeon's Fees,** if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | 80% of PA | 50% of U&C |

| OUTPATIENT | Preferred Providers | Out-of-Network Providers |
|---|---|---|
| **Day Surgery Miscellaneous,** related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index. | 80% of PA | 50% of U&C |
| **Assistant Surgeon** | 50% of PA | 50% of U&C |
| **Anesthetist,** professional services administered in connection with outpatient surgery. | 80% of PA | 50% of U&C |
| **Physician's Visits,** benefits for Physician's Visits do not apply when related to Physiotherapy. | 80% of PA | 50% 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.<br>See Out-of-Network Medical Emergency Services, page 10. | 80% of PA | 80% of U&C |
| **Physiotherapy,** see Exclusion number 26 for additional limitations. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy, unless excluded in the policy.<br>Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. | 80% of PA | 50% of U&C |
| **Diagnostic X-Ray Services** | 80% of PA | 50% of U&C |
| **Laboratory Services** | 80% of PA | 50% of U&C |
| **Injections,** when administered in the Physician's office and charged on the Physician's statement. | 80% of PA | 50% of U&C |
| **Chemotherapy** | 80% of PA | 50% of U&C |
| **Radiation Therapy** | 80% of PA | 50% 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. | 80% of PA | 50% of U&C |
| **Prescription Drugs** | UnitedHealthcare Pharmacy (UHCP)<br>$20 Copay per prescription for Tier 1<br>$35 Copay per prescription for Tier 2<br>$70 Copay per prescription for Tier 3<br>up to a 31-day supply per prescription | $20 Deductible per prescription for generic drugs<br>$35 Deductible per prescription for brand name<br>up to a 31-day supply per prescription |
| **OTHER** | | |
| **Ambulance Services** | 80% of PA | 80% of U&C |
| **Durable Medical Equipment,** a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. *($2,500 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $2,500 maximum are not included in the $500,000 Maximum Benefit)* | 80% of PA | 50% of U&C |
| **Dental Treatment,** made necessary by Injury to Sound, Natural Teeth only.<br>*($100 maximum per tooth) (Benefits are not subject to the $500,000 Maximum Benefit.)* | 80% of U&C | 80% of U&C |
| **Consultant Physician Fees,** when requested and approved by the attending Physician. | 80% of PA | 50% of U&C |
| **Maternity** | See Benefits for Maternity Expenses | |

| OTHER | Preferred Providers | Out-of-Network Providers |
|---|---|---|
| **Complications of Pregnancy** | Paid as any other Sickness | |
| **Elective Abortion** | No Benefits | |
| **Mental Illness Treatment,** services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered. | Paid as any other Sickness | |
| **Substance Use Disorder Treatment** | See Benefits for Treatment of Chemical Dependency | |
| **Reconstructive Breast Surgery Following Mastectomy,** in connection with a covered Mastectomy.<br>See Benefits for Reconstructive Surgery Following Mastectomy. | Paid as any other Sickness | |
| **Diabetes Services,** in connection with the treatment of diabetes.<br>See Benefits for Diabetes. | Paid as any other Sickness | |
| **Approved Clinical Trials** | See Benefits for Covered Clinical Trials | |
| **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.<br>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. | 100% of PA | 50% of U&C |

## 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 cannot refill a prescription until 75% of the applicable supply limit has been used, except under certain circumstances during a state of emergency or disaster.

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

$20 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply

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

$70 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply

Please present your ID card to the network pharmacy when the prescription is filled.

If you do not 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 please visit www.uhcsr.com/Devry and log in to your online account or call 1-855-828-7716.

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

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

### Definitions

**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/devry or call Customer Service 1-855-828-7716.

## Preferred Provider Information

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

**UnitedHealthcare Options PPO.**

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-866-808-8298, 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 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 1-866-808-8298 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.

### Out-of-Network Medical Emergency Services

When Medical Emergency Services for a Medical Emergency are provided by an Out-of-Network Provider, benefits will be based on the billed amount but are subject to the same Copay or Coinsurance amounts that are applicable to Medical Emergency Services provided by a Preferred Provider.

**EXAMPLE OF DETERMINATION OF PAYMENT OBLIGATIONS:**

### Preferred Provider Benefits

**Preferred Provider Coinsurance percentage applied to the Preferred Allowance:**

For example, if the policy pays 90% of Preferred Allowance and the Preferred Allowance is $100; the Company's benefit payment would be 90% x $100 = $90.

The Company would pay $90 and the Insured would be responsible for payment to the Preferred Provider of $10. The billed amount less the Preferred Allowance is an ineligible amount not owed to the Preferred Provider in accordance with an agreement between the Company and provider.

### Out of Network Benefits

**Out of Network Coinsurance percentage applied to the Usual and Customary Charge:**

For example, if the policy pays 80% of Usual and Customary and the Usual and Customary Charge is $100, the Company's benefit payment would be 80% x $100 = $80.

The Company would pay $80 and the Insured would be responsible for payment to the provider of the billed amount less the amount the Company paid.

## Maternity Testing

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

**Initial screening at first visit:**

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

**Each visit:** Urine analysis

**Once every trimester:** Hematocrit and Hemoglobin

**Once during first trimester:** Ultrasound

**Once during second trimester:**

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

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

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

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

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-866-808-8298.

## Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 9 consecutive months and who no longer meet the Eligibility requirements under the Policy are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

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

## Mandated Benefits

### *Benefits for Emergency Services*

Benefits will be paid the same as any other Sickness or Injury for treatment of a Medical Emergency. The Insured should use emergency services, including calling 911 or other telephone access systems utilized to access pre hospital emergency services when appropriate for treatment of a Medical Emergency.

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 Examinations and Laboratory Tests for the screening for the early detection of cervical cancer. Benefits shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control and will include the examination, laboratory fee, and the Physician's interpretation of the laboratory results.

Reimbursement for the laboratory fee will be made only if the laboratory meets accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Examinations and laboratory tests" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

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

### *Benefits for Temporomandibular Joint Disorder*

Benefits will be paid the same as treatment to any other joint in the body for the treatment of Temporomandibular Joint Disorder ("TMJ"). Procedures will include splinting and use of intraoral prosthetic appliances to reposition the bones. Non-surgical treatment of TMJ is subject to a lifetime maximum benefit of $3,500. No benefits will be paid for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, root canal or routine dental treatment.

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 Low-dose Screening Mammography according to the following guidelines:

1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this benefit, "at risk" means the following:
    a. The woman has a personal history of breast cancer;
    b. The woman has a personal history of biopsy-proven benign breast disease;
    c. The woman's mother, sister, or daughter has or has had breast cancer; or
    d. The woman has not given birth prior to the age of 30.
2. One baseline mammogram for any woman thirty-five through thirty-nine years of age, inclusive.
3. A mammogram every other year for any woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Physician.
4. A mammogram every year for any woman fifty years of age or older.

Reimbursement will be made only if the facility where treatment is rendered meets the mammography accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a Physician's interpretation of the results of the procedure.

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

### *Benefits for Surveillance Tests for Women at Risk for Ovarian Cancer*

Benefits will be paid the same as any other Sickness for Surveillance Tests for women age 25 and older At Risk for Ovarian Cancer.

"At risk for ovarian cancer" means either: a) having a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or 2) testing positive for a hereditary ovarian cancer syndrome.

"Surveillance tests" mean annual screening using: a) transvaginal ultrasound, and 2) rectovaginal pelvic examination.

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. Beginning at age 50, benefits will be provided for non-symptomatic Insured Persons for one of the five screening options below:

1. Yearly fecal occult blood test (FOBT); or
2. Flexible sigmoidoscopy every five (5) years; or
3. Yearly fecal occult blood test plus flexible sigmoidoscopy every five (5) years; or
4. Double contract barium enema every five (5) years; or
5. Colonoscopy every ten (10) years.

In addition, upon recommendation of the Physician, medically necessary benefits will be provided for one or more of the screening options, based on American Cancer Society guidelines regarding family history or other factors, regardless of the age of the Insured.

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

### *Benefits for Prostate Specific Antigen (PSA) Tests*

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) or equivalent tests for the presence of prostate cancer when recommended by a Physician.

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

### *Benefits for Reconstructive Breast Surgery Following Mastectomy*

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery following a Mastectomy. Benefits will be paid for all stages and revisions of Reconstructive Breast Surgery performed on a diseased breast, as well as for prostheses and physical complications in all stages of Mastectomy, including lymphedemas. Reconstruction of the nipple/areolar complex following a Mastectomy is covered without regard to the lapse of time between the Mastectomy and the reconstruction upon approval by the treating Physician.

"Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

"Reconstructive breast surgery" means surgery performed as a result of a Mastectomy to re-establish symmetry between the two breasts, and includes reconstruction of the Mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

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

### *Benefits for Diabetes*

Benefits will be paid the same as any other Sickness for medically necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures, used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician or healthcare professional designated by the Physician.

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

### *Benefits for Anesthesia and Hospitalization for Dental Procedures*

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the Physician treating the Insured involved certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

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

### *Benefits for Bone Mass Measurements*

Benefits will be paid the same as any other Sickness for a Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass for Qualified Individuals.

Benefits will be paid for one Bone Mass Measurement every 23 months. Benefits will be paid more frequently when medically necessary. Conditions that may be considered medically necessary include, but are not limited to: 1) monitoring beneficiaries on long-term glucocorticoid therapy of more than three months and 2) to determine the effectiveness of adding an additional treatment regimen for a Qualified Individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

"Bone mass measurement" means a scientifically proven radiologic, radioisotopic, or other procedure performed on a Qualified Individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

"Qualified individual" means any one or more of the following:

an individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;

an individual with radiographic osteopenia anywhere in the skeleton;

an individual who is receiving long-term glucocorticoid (steroid) therapy;

an individual who has primary hyperparathyroidism;

an individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;

an individual who has a history of low-trauma fractures; or

an individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

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

### *Benefits for Prescription Contraceptives*

If the Policy provides coverage for prescription drugs or devices, benefits will be paid the same as any other prescription drug or device for any contraceptive drug or device including the insertion or removal and any medical examination associated with the use of such contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid the same as any other Sickness for outpatient contraceptive services provided by a Physician.

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

### *Benefits for Newborn Hearing Screening*

Benefits will be paid the same as any other Sickness for Physician ordered newborn hearing screening.

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

### *Benefits for the Treatment of Lymphedema*

Benefits will be paid the same as any other Sickness for the diagnosis, evaluation, and treatment of lymphedema including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a Physician.

Gradient Compression Garments:

1. require a prescription;
2. are custom-fit for the Insured Person; and
3. do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

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

### *Benefits for Covered Clinical Trials*

Benefits will be paid the same as any other Sickness for participation in phase I, phase II, phase III, and phase IV Covered Clinical Trials by an Insured who meets protocol requirements of the trials and when informed consent is provided.

Only Covered Medical Expenses for the costs of health care services which are a Medical Necessity and associated with participation in a Covered Clinical Trial, including those related health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring will be paid and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

No benefits will be provided for non-FDA approved drugs provided or made available to an Insured patient who received the drug during a Covered Clinical Trial after the clinical trial has been discontinued.

The following clinical trial costs are not covered:

1. Costs of services that are not health care services;
2. Cost of services provided solely to satisfy data collection and analysis needs;
3. Costs of services related to investigation drugs and devices; and
4. Costs of services that are not provided for the direct clinical management of the Insured patient.

“Covered Clinical Trials” means phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:

1. involve the treatment of life-threatening medical conditions;
2. are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives;
3. have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives;
4. must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;

5. must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and
6. must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

In the event a claim contains charges related to services for which coverage is required under this benefit, and those charges cannot be separated from costs related to services that are not covered under this benefit, the Company shall deny the claim.

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

### *Benefits for Maternity Expenses*

Benefits will be paid the same as any other Sickness for Inpatient and outpatient maternity care.

Inpatient benefits will include:

1. A minimum of forty-eight (48) hours of inpatient care following a vaginal delivery for the mother and her Newborn Infant after childbirth; and
2. A minimum of ninety-six (96) hours of inpatient care following a cesarean section for the mother and Newborn Infant after childbirth.

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. In the case of a decision to discharge the mother and her Newborn Infant from the Inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, benefits will include Timely Postdelivery Care. Timely Postdelivery Care shall be provided to a mother and her Newborn Infant by a registered nurse, Physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health. Such follow-up care shall be provided in:

1. The home, a provider's office, a Hospital, a birthing center, an immediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or
2. Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

"Timely PostDelivery Care" means health care that is provided:

1. Following the discharge of a mother and her Newborn Infant from the Inpatient setting; and
2. In a manner that meets the health care needs of the mother and her Newborn Infant, which provides for the appropriate monitoring of the conditions of the mother and Newborn Infant, and occurs not later than the 72-hour period immediately following discharge.

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

### *Benefits for Hearing Aids*

Benefits will be paid for one hearing aid per hearing-impaired ear up to $2,500 per hearing aid every 36 months when Medically Necessary and ordered by a Physician or audiologist licensed in the state. Coverage includes:

1. Initial hearing aids and replacement hearing aids not more frequently than every 36 months.
2. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Insured Person.
3. Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

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

### *Benefits for Treatment for Chemical Dependency*

Benefits will be paid the same as any other Sickness for treatment of Chemical Dependency.

Benefits will be paid for the necessary care and treatment of Chemical Dependency for services received from any of the following providers:

1) The following units of a Hospital licensed under Article 5 of General Statutes Chapter 131E:
   a) Chemical Dependency units in facilities licensed after October 1, 1984;
   b) Medical units;
   c) Psychiatric units; and
2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a) Chemical Dependency units in psychiatric hospitals;
   b) Chemical Dependency Hospitals;
   c) Residential Chemical Dependency treatment facilities;
   d) Social setting detoxification facilities or programs;
   e) Medical detoxification or programs; and
3) Duly licensed Physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such Physicians or psychologists in facilities described in 1) and 2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984 under Article 2 of General Statutes Chapter 122C.

As used in this endorsement, the term "Chemical Dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

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

## Definitions

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

**COPAY/COPAYMENT** means a specified dollar amount that an 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.

**CREDITABLE COVERAGE** means benefits or coverage provided under:

a. A group health plan as defined in G.S. 58-68-25(a)(4b).
b. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.
c. Part A or part B of title XVIII of the Social Security Act.
d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
e. Chapter 55 of title 10, United States Code.
f. A medical care program of the Indian Health Service or of a tribal organization.
g. A State health benefits risk pool.
h. A health plan offered under chapter 89 of title 5, United States Code.
i. A public health plan (as defined in federal regulations).
j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)).
k. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits as described in G.S. 58-68-25(b). However, short-term limited duration health insurance coverage shall be considered creditable coverage.

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

**DEPENDENT** means the spouse (husband or wife) of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and,
2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

**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

**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.

**IN-NETWORK COVERED MEDICAL EXPENSES** means Covered Medical Expenses that are received under the terms of the policy from providers under contract with or approved in advance by the Company and means Medical Emergency services regardless of the status or affiliation of the provider of such services.

**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 a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention would result in any of the following:

1) Placing the health of an individual, or with respect to a pregnant woman, the health of the women or her unborn child, in serious jeopardy.
2) Serious impairment of bodily functions.
3) Serious dysfunction of any body organ or part.

**MEDICAL EMERGENCY SERVICES** means health care items and services furnished or required to screen for or treat a Medical Emergency until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

**MEDICAL NECESSITY** means those services or supplies that are:

1) Provided for the diagnosis, treatment, cure, or relief of a health condition, Sickness, Injury, or disease; and, not for experimental, investigational, or cosmetic purposes, except as allowed for covered clinical trials.
2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, Sickness, Injury, disease, or its symptoms.
3) Within generally accepted standards of medical care in the community.
4) Not solely for the convenience of the Insured, the Insured's family, or the provider.

For medically necessary services, the Company may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

**NEWBORN INFANT, ADOPTED OR FOSTER CHILD** means any child born of an Insured or placed with an Insured while that person is insured under this policy. Such child will be covered under the policy from the moment of birth or placement for the first 31 days after birth or placement. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects or birth abnormalities including treatment of cleft lip and cleft palate, prematurity and nursery care.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. If additional premium is required to continue the coverage the Insured must, within the 31 days after the child's birth or placement: 1) apply to us; and 2) pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth or placement.

If family coverage is in force and no additional premium is required, enrollment/notification of the new Dependent within the specified period of time will not be required nor penalties applied for failure to do so.

**OUT-OF-NETWORK COVERED MEDICAL EXPENSES** means non-emergency Covered Medical Expenses that are not received according to the terms of the policy including services from affiliated providers that are received without the approval of the Company.

**OUT-OF-NETWORK PROVIDER** means a health care provider who has not agreed to accept special reimbursement or other terms for health care services from the Company for health care services on a fee-for-service basis.

**PRE-EXISTING CONDITION** means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within a twelve-month period immediately preceding the Insured's Effective Date under the policy.

**PREFERRED PROVIDER** means a health care provider who has agreed to accept special reimbursement or other terms for health care services from the Company for health care services on a fee-for-service basis.

**SICKNESS** means sickness or illness 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 where service is rendered. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

## Exclusions and Limitations

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

1. Acne;
2. Acupuncture;
3. Allergy, including allergy testing;
4. Nicotine addiction, except as specifically provided in the policy

5. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the policy;
6. Biofeedback;
7. Circumcision, except as specifically provided for a Newborn Infant during an Inpatient maternity hospital stay provided under the Benefits for Maternity Expenses;
8. Congenital conditions, except as specifically provided for Newborn Infant or Adopted or Foster Child;
9. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for Newborn Infant or Adopted or Foster Child;
10. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;
11. Dental treatment, except for accidental Injury to Sound, Natural Teeth. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit;
12. Elective Surgery or Elective Treatment;
13. Elective abortion;
14. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses; vision correction surgery, or other treatment for visual defects and problems, except when due to a covered Injury or process. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit;
15. Flat foot conditions; supportive devices for the foot; subluxations of the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);
16. Health spa or similar facilities; strengthening programs;
17. Hearing examinations, except as specifically provided in the Benefits for Newborn Hearing Screening; hearing aids, except as specifically provided in the Benefits for Hearing Aids; 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. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit;
18. Hirsutism; alopecia;
19. Hypnosis;
20. 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. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit;
21. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

22. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except for a Medical Emergency when traveling for academic study abroad programs, business or pleasure;
23. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
24. Investigational services; except as specifically provided in the Benefits for Covered Clinical Trials;
25. Lipectomy;
26. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;
27. Voluntary participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting, except when as a direct result of domestic abuse;
28. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months; The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous Creditable Coverage under a prior health insurance 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;
29. 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 Benefits for Diabetes;
    b Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The National Comprehensive Cancer Network Drugs and Biologics Compendium; (2) The ThomsonMicromedex DrugDex; (3) The Elsevier Gold Standard's Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services;
    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, except for a Newborn Infant, Adopted or Foster Child who requires growth hormones for the treatment of a congenital condition; or
    i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

30. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
31. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Benefits for Covered Clinical Trials;
32. Routine Newborn Infant Care, well-baby nursery and related Physician charges; except as specifically provided in the policy;
33. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit or any North Carolina mandated benefit included under this policy;
34. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
35. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
36. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
37. Sleep disorders;
38. Speech therapy; naturopathic services;
39. Suicide or attempted suicide while sane or insane (including intentional drug overdose); or intentionally self-inflicted Injury;
40. Supplies, except as specifically provided in the policy;
41. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
42. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
43. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
44. Weight management, weight reduction, nutrition programs, treatment for obesity, (except surgery for morbid obesity), surgery for removal of excess skin or fat. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit.

## Frontier MEDEX Global Emergency Services

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

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

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

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

**Key Services include:**

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

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

**To access services please call:**

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

**(410) 453-6330** Collect outside the United States

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

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

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

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

## Rebates/Inducements

From time to time the Company may offer or provide certain persons who become Insureds with the Company with discounts for goods or services. In addition, the Company may arrange for third party service providers such as pharmacies, optometrists, and dentists to provide discounted goods and services to those persons who become Insureds of the Company. While the Company has arranged these goods, services and/or third party provider discounts, the third party service providers are liable to the Insureds for the provision of such goods and/or services. The Company is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Company is not liable to the Insured for the negligent provision of such goods and/or services by the third party service providers.

## Pre-existing Condition Provision

### Pre-existing Condition Limitations

This policy contains a provision limiting coverage for pre-existing conditions. Pre-existing conditions are covered under this policy 12 months after the effective date of coverage. Pre-existing conditions means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within a twelve-month period immediately preceding the Insured's Effective Date under the policy.

This Pre-existing Condition Limitation does not apply to an Insured Person who is under age 19 including a Newborn Infant, Adopted or Foster Child.

### Creditable Coverage Requirements

The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous Creditable Coverage under a prior health insurance policy which provided benefits similar to this policy. The coverage must be continuous to a date within 63 days prior to the Insured's effective date under this policy.

There is no time limit on the amount of time an Insured has to present a certificate or evidence of Creditable Coverage.

## Resolution of Grievance Process

A Grievance is a written complaint submitted by or on behalf of an Insured Person regarding the following:

1) The Company's decisions, policies, or actions related to availability, delivery or quality of health care services;
2) Claims payment, handling or reimbursement for health care services; or
3) The contractual relationship between an Insured Person and the Company.
4) A Grievance cannot be filed for a decision rendered solely on the basis the policy does not provide benefits for the health care services in question, if the exclusion of the specific service requested is clearly stated in this Certificate.

## Grievance Informal Review

An Insured Person may voluntarily request a review of any decision, policy, or action made by the Company that affects the Insured. The Company provides for immediate informal review after an event that causes a dispute.

1) If the Grievance concerns a clinical issue and the informal consideration decision is not in favor of the Insured Person, the request will be treated as a first-level Grievance review. The Company will provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material.
2) If the Grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the Insured, the Company will issue a written decision that includes the availability of the Commissioner's office and the Managed Care Assistance Program for assistance, including the telephone number and address of the office of both.
3) If the Company is unable to render an informal consideration decision within 10 business days after receipt of the Grievance, the Company on the day the Company determines an informal consideration decision cannot be made before the tenth business day after receipt of the Grievance, the Company will provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material for an Internal Appeal.

## First-Level Grievance Review

The Insured Person or their Authorized Representative has the right to submit a Grievance.

The written Grievance review request should include:

1. A statement specifically requesting to submit a Grievance;
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 for the submission of the Grievance; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 1-888-251-6259 with any questions regarding the internal Grievance review process. The written request for an internal Grievance review should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Within 3 business days after receiving a Grievance other than a Grievance concerning the quality of clinical care received by the Insured, the Company shall provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material.

For a Grievance concerning the quality of clinical care delivered by the Insured's provider, the Company will provide acknowledgement of the Grievance to the Insured within 10 business days. The acknowledgement shall advise the Insured Person of the following:

1. The Company will refer the Grievance to its quality assurance committee for review and consideration or any appropriate action against the provider; and
2. State law does not allow for a second-level Grievance review for a Grievance concerning quality of care.

The Company shall issue a written decision to the Insured or an Insured's Authorized Representative within 30 days after receiving a Grievance.

## Second-Level Internal Grievance Review

An Insured or an Insured's Authorized Representative may submit a request for a second-level Grievance review when not satisfied with the first-level Grievance review decision. The Company shall, within 10 business days after receiving a request for a second-level Grievance review, provide notice of receipt and provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material.

The second-level review panel will schedule and hold a review meeting within 45 days after receiving a request for a second-level review. The Insured Person shall be notified in writing within at least 15 days before the review meeting date. The Insured Person's right to a full review will not be conditioned on the Insured's appearance at the review meeting.

The Company shall issue a written decision to the Insured or an Insured's Authorized Representative within 7 business days after completing the review meeting.

## NOTICE OF APPEAL RIGHTS FOR NONCERTIFICATIONS AND ADVERSE DETERMINATIONS

### Internal Appeal of a Noncertification or Adverse Determination

The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal of Noncertification or Adverse Determination within 180 days after receipt of a notice of a Noncertification or Adverse Determination and include the following information:

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.

An expedited internal appeal of a Noncertification or Adverse Determination may be requested by an Insured Person or the Insured's provider only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of an Insured Person or jeopardize the Insured's ability to regain maximum function.

In consultation with a medical doctor licensed to practice medicine in the state of North Carolina, the Company shall provide written notification of the decision to the Insured Person and the Insured's provider:

1. within 30 days after the request for a nonexpedited appeal; or
2. as soon as reasonably possible, but not later than 4 days after receipt of information justifying the expedited review.

If the decision is not in favor of the Insured Person; the Insured has the right to file an external review request with the Commissioner of the North Carolina Department of Insurance. If the Insured Person has a medical condition where the time frame for completion of an expedited internal review would reasonably be expected to seriously jeopardize the life or health of the Insured Person, the Insured Person may file a request for an expedited external review at the same time the Insured Person files for an expedited internal review. The Commissioner will determine whether the covered person shall be required to complete the internal expedited review before conducting the expedited external review.

## 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 1-888-315-0447. The written request for an Expedited Internal Appeal should be sent to: UnitedHealthcare StudentResources, PO Box 809025, Dallas, TX 75380-9025.

## Right to External Independent Review

North Carolina law provides for the review of Noncertification decisions by an external independent review organization (IRO). Except for cases when the Insured requests an expedited appeal, external review is available to the Insured only after he or she has completed the Company's internal appeal process for Noncertification. The Insured or an Authorized Representative must make a request to the North Carolina Department of Insurance (NCDOI) for an external review with 120 days of the date of the notice of Noncertification or second-level Grievance decision. The NCDOI administers this service at no charge to the Insured and will arrange for the review of the Insured's case by an IRO once the NCDOI establishes that the request is complete and eligible for review.

## Expedited External Review

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

a. A Noncertification decision if:
   (i) the Insured Person or the Authorized Representative has filed a request for an expedited appeal of Noncertification; and
   (ii) the Noncertification involves a medical condition for which the timeframe for completing an expedited appeal of Noncertification would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

b. An appeal decision upholding a Noncertification, if:
   (i) the Noncertification involves a medical condition for which the timeframe for completing an expedited internal review of a Noncertification would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; and
   (ii) the Insured Person or Authorized Representative has filed a request for an expedited internal review of a Noncertification.

## Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance department at the following address:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
877-885-0231

### Questions Regarding Appeal Rights

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

### Managed Care Patient Assistance Program

The Managed Care Patient Assistance Program (MCPAP) is available to assist you with insurance related problems and questions. You may contact the Managed Care Patient Assistance Program at:

Managed Care Patient Assistance Program
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free: (877) 885-0231
Telephone: (919) 733-6272 and Fax: (919) 807-6865

## General Provisions

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

**PAYMENT OF PREMIUM:** All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under this policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Insured has given the Company written notice of discontinuance.

**NOTICE OF CLAIM:** Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025, or to any authorized agent of the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company.

**CLAIM FORMS:** Claim forms are not required.

**PROOF OF LOSS:** Written proof of loss must be furnished to the Company at its said office within 180 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIM:** Indemnities payable under this policy for any loss will be paid within 30 calendar days upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than 30 days of receipt of the claim, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Within 30 days of receipt of the claim, the Company may request additional information in order to process all or part of the claim. If the requested additional information is not received within 90 days after the request is made, the Company shall deny the claim and send notice of the denial. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid. Payment of claims not made in accordance with these provisions shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid.

**PHYSICAL EXAMINATION:** As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

**LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

**RIGHT OF RECOVERY:** Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made. This provision does not apply to recovery of third party liability settlements.

**MORE THAN ONE POLICY:** Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

**CERTIFICATE OF CREDITABLE COVERAGE:** A certificate of creditable coverage will be provided to the Insured at the time coverage ceases under the Policy, and upon request on behalf of the Insured made no later than 24 months after the date coverage ended. The certification will be a written certification of the period of creditable coverage of the insured under the Policy and any waiting period and affiliation period, if applicable, imposed with respect to the Insured for any coverage under the Policy.

## Online Access to Account Information

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

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

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

## UnitedHealth Allies

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

## ID Cards

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

## Collegiate Assistance Program

Insured Students have access to nurse advice 24 hours a day, 7 days a week by dialing the number listed on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses, both English and Spanish speaking. These Registered Nurses can help students determine if they need to seek medical care immediately and get unbiased, confidential answers to health questions. A health Information Library is also available in 160 support languages.

## Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, 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) Bills should be received by the Company within 180 days of service or as soon as reasonably possible to be considered for payment. Bills submitted after one year and 180 days from the date of service 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
1-866-808-8298
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 Certificate as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

**This Certificate is based on Policy Number 2013-278-11**

DeVry University

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2013-278-11

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 (9/18/2013)

- Schedule of Benefits, Inpatient – delete "Benefits do not apply when related to surgery."
- Schedule of Benefits, Outpatient – Change to "Benefits for Physician's Visits do not apply when related to Physiotherapy."
- Definition for Ususal & Customary Charges - changed to "locality where service is rendered"