



# 2013-2014

**STUDENT  
INJURY AND SICKNESS  
INSURANCE PLAN**

**The  
University  
of Akron**

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

**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 1-800-767-0700. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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## **Privacy Policy**

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We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or visiting us at [www.uhcsr.com/uakron](http://www.uhcsr.com/uakron).

## **Eligibility**

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All registered students taking six or more credit hours, Doctoral Students, ELI Students, and other Special Academic Program Students are eligible to enroll in this insurance Plan. All registered International students taking credit hours are automatically enrolled in this insurance Plan at registration unless proof of comparable coverage is furnished.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate 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 husband or wife and dependent children under 26 years of age. Dependent Eligibility expires concurrently with that of the Insured student. Eligible students who do enroll may also cover a dependent child until the age of twenty-eight (28) years under certain circumstances. Dependent Eligibility expires concurrently with that of the Insured student.

## **Effective and Termination Dates**

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The Master Policy becomes effective at 12:01 a.m., **August 20, 2013**. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., **August 19, 2014**. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

## **Extension of Benefits After Termination**

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The coverage provided under the policy ceases on the Termination Date. However, if an Insured is hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 60 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.

## **Student Health Center (SHC) Referral Required Students Only**

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The student must use the services of the Health Center first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained will be subject to an additional \$200 Deductible. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A SHC referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. The student must return to SHC for necessary follow-up care.
2. When the Student Health Center is closed.
3. Medical care received when the student is more than 30 miles from campus.
4. Medical care obtained when a student is no longer able to use the SHC due to a change in student status.
5. Maternity, obstetrical and gynecological care.
6. Mental Illness treatment and Substance Use Disorder treatment.

Dependents are not eligible to use the SHC and therefore are exempt from the above limitations and requirements.

## **University Health Services**

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Please contact the University Health Service at (330) 972-7808 or go to Student Recreation & Wellness Center, Room 260 for hours of operation. They are closed Saturday, Sunday, and University Holidays.

## **Pre-Admission Notification**

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

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

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

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

# Schedule of Medical Expense Benefits

## Injury and Sickness

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

**Deductible Preferred Provider: \$200 (For Each Injury or Sickness)**  
(Maximum of 2 Deductibles per Insured Person per Policy Year)

**Deductible Out-of-Network Provider: \$400 (For Each Injury or Sickness)**  
(Maximum of 2 Deductibles per Insured Person per Policy Year)

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

The Preferred Provider is United Healthcare 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 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.

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
<p><b>Room and Board Expense</b>, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital. (90 days maximum per Hospital Confinement for each Injury or Sickness.)</p>	80% of PA	60% of U&C
<p><b>Intensive Care</b></p>	80% of PA	60% of U&C
<p><b>Hospital Miscellaneous Expense</b>, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.</p>	80% of PA	60% of U&C

INPATIENT	Preferred Providers	Out-of-Network Providers
<b>Routine Newborn Care</b> , while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
<b>Physiotherapy</b>	80% of PA	60% of U&C
<b>Surgeon's Fees</b> , if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of U&C
<b>Assistant Surgeon</b>	80% of PA	60% of U&C
<b>Anesthetist</b> , professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
<b>Registered Nurse's Services</b> , private duty nursing care.	80% of PA	60% of U&C
<b>Physician's Visits</b> , non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	60% of U&C
<b>Pre-Admission Testing</b> , payable within 3 working days prior to admission.	80% of PA	60% of U&C
OUTPATIENT		
<b>Surgeon's Fees</b> , if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of U&C
<b>Day Surgery Miscellaneous</b> , related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of U&C
<b>Assistant Surgeon</b>	80% of PA	60% of U&C
<b>Anesthetist</b> , professional services administered in connection with outpatient surgery.	25% of Surgery Allowance	

OUTPATIENT	Preferred Providers	Out-of-Network Providers
<b>Physician's Visits</b> , benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	80% of PA	60% of U&C
<b>Physiotherapy</b> , Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. <i>(Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.)</i>	80% of PA	60% of U&C
<b>Medical Emergency Expenses</b> , facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. <i>(The Copay/per visit Deductible will be waived if admitted to the Hospital.)</i>	80% of PA \$150 copay per visit	60% of U&C \$150 Deductible per visit
<b>Diagnostic X-ray Services</b>	80% of PA \$10 copay per visit	60% of U&C \$10 Deductible per visit
<b>Radiation Therapy</b>	80% of PA	60% of U&C
<b>Chemotherapy</b>	80% of PA	60% of U&C
<b>Laboratory Services</b>	80% of PA \$10 copay per visit	60% of U&C \$10 Deductible per visit
<b>Tests &amp; Procedures</b> , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of U&C
<b>Injections</b> , when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C
<b>Prescription Drugs</b>	UnitedHealthcare Pharmacy (UHCP) \$15 Copay per prescription for Tier 1 \$30 Copay per prescription for Tier 2 up to a 31-day supply per prescription.	No Benefits



OTHER	Preferred Providers	Out-of-Network Providers
<b>Ambulance Services</b>	80% of U&C	80% of U&C
<b>Durable Medical Equipment</b> , a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.	80% of U&C	80% of U&C
<b>Consultant Physician Fees</b> , when requested and approved by attending Physician.	80% of PA	60% of U&C
<b>Dental Treatment</b> , made necessary by Injury to Sound, Natural Teeth only. <i>(Benefits are not subject to the \$500,000 Maximum Benefit.)</i>	80% of U&C	80% of U&C
<b>Mental Illness Treatment</b> , services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered. (See also Benefits for Biologically Based Mental Illness.)	Paid as any other Sickness	
<b>Substance Use Disorder Treatment</b> , services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	
<b>Maternity</b> , benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier. See Also Benefits for Maternity Follow-Up Care.	Paid as any other Sickness	
<b>Complications of Pregnancy</b>	Paid as any other Sickness	
<b>Elective Abortion</b>	No Benefits	

OTHER	Preferred Providers	Out-of-Network Providers
<p><b>Preventive Care Services</b>, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the <i>United States Preventive Services Task Force</i>; 2) immunizations that have in effect a recommendation from the <i>Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</i>; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>.</p> <p>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.</p>	100% of PA	No Benefits
<p><b>Reconstructive Breast Surgery Following Mastectomy</b>, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.</p>	Paid as any other Sickness	
<p><b>Diabetes Services</b>, in connection with the treatment of diabetes for Medically Necessary: 1) outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals; and 2) Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.</p>	Paid as any other Sickness	

## **Preferred Provider Information**

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

UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

"Preferred Allowance" means the amount a Preferred Provider and In-Network 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 out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

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

### **Inpatient Expenses**

**PREFERRED PROVIDERS** - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities. Call 1-800-767-0700 for information about Preferred Hospitals.

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

### **Outpatient Hospital Expenses**

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

### **Professional & Other Expenses**

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

## **UnitedHealthcare Pharmacy Benefits**

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

You are responsible for paying the applicable Copayments. 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/uakron](http://www.uhcsr.com/uakron) or call 1-855-828-7716 for the most up-to-date tier status.

\$15 Copay per prescription order or refill for a Tier 1 Prescription Drug up to 31 day supply

\$30 Copay per prescription order or refill for a Tier 2 Prescription Drug up to 31 day supply

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

### **Additional Exclusions**

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

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

### **Definitions**

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

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

## **Maternity Testing**

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

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

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

**Each visit:** Urine analysis

**Once every trimester:** Hematocrit and Hemoglobin

**Once during first trimester:** Ultrasound

**Once during second trimester:**

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

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

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

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

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

## **Accidental Death and Dismemberment Benefits**

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### **Loss of Life, Limb or Sight**

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

#### **For Loss Of:**

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

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

## **Coordination of Benefits**

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

## **Mandated Benefits**

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### ***Benefits for Biologically Based Mental Illness***

Benefits will be paid the same as any other Sickness for the treatment of Biologically Based Mental Illness if both of the following apply:

- 1) The Biologically Based Mental Illness is clinically diagnosed by a Physician authorized to practice medicine and surgery or osteopathic medicine and surgery, a psychologist, a professional clinical counselor, professional counselor, independent social worker, or a clinical nurse specialist whose nursing specialty is mental health.
- 2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

“Biologically Based Mental Illness” means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

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

### ***Benefits for Maternity Follow-Up Care***

Benefits shall be provided for maternity follow-up care for Physician-directed follow-up care for a mother and her newborn. Benefits shall include:

1. Physical assessment of the mother and newborn.
2. Parent education.
3. Assistance and training in breast or bottle feeding.
4. Assessment of the home support system.
5. Performance of any medically necessary and appropriate clinical tests.
6. Any other services consistent with follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Benefits apply to services provided in a medical setting or through home health care visits when such visits are performed by a provider who is knowledgeable and experienced in maternity and newborn care.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, then benefits will be paid for follow-up care that is provided within seventy-two (72) hours after discharge. When the mother or newborn receive at least the number of hours in inpatient required to be covered, then benefits will be paid for medically necessary follow-up care as determined by the health care provider responsible for discharging the mother or newborn.

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

## ***Benefits for Cancer Clinical Trials***

Benefits will be paid the same as any other Sickness for Routine Patient Care administered to an Insured participating in any stage of an Eligible Cancer Clinical Trial, if those expenses would be paid if the Insured was not participating in a clinical trial.

"Eligible Cancer Clinical Trial" means a cancer clinical trial that meets all of the following criteria:

- a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- d) The trial does one of the following:
  - i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - ii) Tests responses to a health care service, item or drug for the treatment of cancer;
  - iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items or drugs for the treatment of cancer;
  - iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.
- e) The trial is approved by one of the following entities:
  - i) The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  - ii) The United States Department of Defense;
  - iii) The United States Department of Veterans' Affairs

"Routine Patient Care" means all health care services consistent with the coverage provided in the policy for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a Cancer Clinical Trial, and that was not necessitated solely because of the trial.

Benefits will not be paid for:

- a) A health care service, item, or drug that is the subject of the cancer clinical trial.
- b) A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- d) Transportation, lodging, food, or other expenses for the Insured, or a family member of companion of the Insured, that are associated with the travel to or from a facility providing the cancer clinical trial;
- e) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- f) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsors of the cancer clinical trial.

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

## **Definitions**

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

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

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

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

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

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

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

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

**MEDICAL EMERGENCY** means the occurrence of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

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

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

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



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

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

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

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

**USUAL AND CUSTOMARY CHARGES** means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

## **Exclusions and Limitations**

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

1. Acne;
2. Acupuncture;
3. Allergy, including allergy testing;
4. Addiction, such as: nicotine addiction, except as specifically provided in the policy; and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
5. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation;
6. Biofeedback;
7. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
8. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
9. 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;
10. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
11. Elective Surgery or Elective Treatment;
12. Elective abortion;
13. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered injury or disease process;
14. 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);

15. Hearing examinations; or 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;
16. Hirsutism; alopecia;
17. 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;
18. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
19. Injury sustained while (a) participating in any interscholastic, club, 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;
20. Investigational services;
21. Organ transplants, including organ donation;
22. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
23. Prescription Drugs, services or supplies as follows:
  - a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
  - b. Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
  - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
  - d. Products used for cosmetic purposes;
  - e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
  - f. Anorectics - drugs used for the purpose of weight control;
  - g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene or Viagra;
  - h. Growth hormones; or
  - i. Refills in excess of the number specified or dispensed after (1) year of date of the prescription;
24. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
25. 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;
26. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
27. 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;
28. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

29. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
30. 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;
31. Sleep disorders;
32. Suicide or attempted suicide while sane or insane; or intentionally self-inflicted Injury;
33. Supplies, except as specifically provided in the policy;
34. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy;
35. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
36. 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
37. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

## **Collegiate Assistance Program**

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

## **FrontierMEDEX: Global Emergency Medical Assistance**

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

Please visit your school's insurance coverage page at [www.uhcsr.com](http://www.uhcsr.com) for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

**To access services please call:**

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

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

Services are also accessible via e-mail at [operations@frontiermedex.com](mailto:operations@frontiermedex.com).

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

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and ID Number on the front of the FrontierMEDEX 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 your FrontierMEDEX information in MyAccount at [www.uhcsr.com](http://www.uhcsr.com) for additional information, including limitations and exclusions.

# **Notice of Appeal Rights**

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## **Right to Internal Appeal**

### **Standard Internal Appeal**

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

The written Internal Appeal request should include:

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

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

### **Expedited Internal Appeal**

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

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

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

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

## **Right to External Independent Review**

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

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

### **Standard External Review**

A Standard External Review request must be submitted in writing within 180 days of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

### **Expedited External Review**

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

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and

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

or

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

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

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

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

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

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

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
  - a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
  - b. Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective is not initiated promptly;

or

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

## Where to Send External Review Requests

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

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

## Questions Regarding Appeal Rights

Contact Customer Service at 1-800-767-0700 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

## Online Access to Account Information

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

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

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

## ID Cards

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

## UnitedHealth Allies

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

## **Claim Procedure**

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In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within 90 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in absence of legal capacity.

***This Plan is Underwritten by:***

UnitedHealthcare Insurance Company

***Submit all Customer Service or Claims Inquiries to:***

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-800-767-0700

customerservice@uhcsr.com

claims@uhcsr.com

Website: www.uhcsr.com

***Serviced Locally by:***

Leonard Insurance Services

4244 Mt. Pleasant Rd.

North Canton, Ohio 44720-1904

Direct: 330-266-1904

Toll Free: 1-800-451-1904

www.leonardinsurance.com

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

This Brochure is based on Policy # 2013-643-1

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