2013-2014

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

Lincoln University

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

12-BR-MO

24-722-1

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $500,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-767-0700. 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.

Table of Contents

Privacy Policy

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

Eligibility

All registered students taking 12 or more credit hours are required to enroll in this insurance Plan, unless proof of comparable coverage is furnished. All registered students taking less than 12 credit hours are eligible to enroll in this insurance Plan. International students taking credit hours are automatically enrolled in this insurance Plan at registration and the premium for coverage is added to their tuition billing.

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

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse, husband or wife, and dependent children under 26 years of age.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 15, 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 14, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

Extension of Benefits After Termination

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

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

After 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

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 are excluded from coverage. 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. When service is rendered at another facility during break or vacation periods.
4. Medical care received when the student is more than 50 miles from campus.
5. Medical care obtained when a student is no longer able to use the SHC due to a change in student status.
6. Maternity, obstetrical and gynecological care.
7. 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.

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: $100 (Per Insured Person) (Per Policy Year)
Deductible Out of Network: $600 (Per Insured Person) (Per Policy Year)

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

Out-of-Pocket Maximum Preferred Providers:
$5,000 (Per Insured Person, Per Policy Year)

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

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

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

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

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

Student Health Center Benefits: The Policy Deductible will be waived when a student first uses the services at the Student Health Center.

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	60% of U&C
Intensive Care	80% of PA	60% of U&C
Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of U&C

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

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Physiotherapy, see exclusion number 27 for additional limitations. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy, unless excluded in the policy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness, except as provided under Benefits for Chiropractic Care. See also benefits for Chiropractic Care.	80% of PA	60% of U&C
Medical Emergency Expenses, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. *(The Copay/per visit Deductible is in addition to the policy Deductible and will be waived if admitted to the Hospital.)*	80% of PA / $100 Copay per visit	60% of U&C / $100 Deductible per visit
Diagnostic X-ray Services	80% of PA	60% of U&C
Radiation Therapy	80% of PA	60% of U&C
Chemotherapy	80% of PA	60% of U&C
Laboratory Services	80% of PA	60% of U&C
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C
Prescription Drugs, if a covered Prescription Drug is prescribed in a single dosage amount and the drug is not manufactured in such single dosage amount and requires dispensing in a combination of different manufactured dosage amounts only one co-payment or Deductible for the dispensing of the combination of the manufactured dosages that equal the prescribed dosage for such Prescription Drug will apply. A new Co-payment or Deductible will apply to each 31 day supply of the Prescription Drug.	UnitedHealthcare Pharmacy (UHCP) / $10 Copay per prescription for Tier 1 / $20 Copay per prescription for Tier 2 / $40 Copay per prescription for Tier 3 / up to a 31-day supply per prescription *(Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.)*	No Benefits

OTHER	Preferred Providers	Out-of-Network Providers
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. *($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum are not included in the $500,000 Maximum Benefit.)*	80% of PA	60% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	80% of PA	60% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *($1,000 maximum Per Policy Year) (Benefits are not subject to the $500,000 Maximum Benefit.)*	80% of PA	80% of U&C
Mental Illness Treatment, see Benefits for Chemical Dependency and Mental Illness	Paid as any other Sickness	
Substance Use Disorder Treatment, see Benefits for Chemical Dependency and Mental Illness	Paid as any other Sickness	
Maternity, see Benefits for Maternity Expense	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Reconstructive Breast Surgery Following Mastectomy, see Benefits for Prosthetic Device and Reconstructive Surgery.	Paid as any other Sickness	
Diabetes Services, benefits will be provided to Insureds with gestational, type I or type II diabetes 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.	Paid as any other Sickness	

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

Preferred Provider Information

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

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

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

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

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

Inpatient Expenses

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

UnitedHealthcare Pharmacy Benefits

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

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. If you are actively taking a Prescription Drug Product, we will notify you electronically, or in writing, upon your request, at least thirty days prior to any deletions, other than generic substitutions. Please access www.uhcsr.com or call 1-855-828-7716 for the most up-to-date tier status.

$10 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

$20 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

$40 Copay per prescription order or refill for a Tier 2 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 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 and log in to your online account or call 877-417-7345.

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
4. Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug

Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that re available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

Definitions

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

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

Maternity Testing

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

Initial screening at first visit:

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

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

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

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

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

Once during third trimester: Group B Strep Culture

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

Coordination of Benefits Provision

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

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

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

For Loss Of:

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

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

Mandated Benefits

Benefits for Treatment of Chemical Dependency and Mental Illness

Benefits will be paid the same as any other Sickness for treatment of Chemical Dependency and Mental Illness subject to the following limitations and conditions:

Chemical Dependency

Benefits will be paid for Nonresidential Treatment Programs or partial- or full-Day Program Services.

Benefits will be paid for Residential Treatment Programs.

Benefits will be paid for Medical or Social Setting Detoxification.

Mental Illness

Benefits will be paid as any other Sickness for partial- or full-Day Program Services and Residential Treatment Programs rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals.

Benefits will be paid for inpatient treatment as any other Sickness.

Benefits will be paid for the diagnosis or assessment of Mental Illness. Payment of benefits is not dependent upon findings.

Diagnosis or assessment of Mental Illness may be provided by any Physician regardless of any Preferred Provider Provisions that may apply to other benefits under the policy.

For the purposes of this endorsement, the following terms have the meanings as defined.

"Chemical dependency" means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

"Day program services" means a structured, intensive day or evening treatment or partial hospitalization program certified by the department of mental health or accredited by a nationally recognized organization.

"Episode" means a distinct course of chemical dependency treatment separated by at least thirty days without treatment.

"Medical detoxification" means Hospital inpatient or residential medical care to ameliorate acute medical condition associated with Chemical Dependency.

"Nonresidential treatment program" means a program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting.

"Mental illness" means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, except for Chemical Dependency.

"Residential treatment program" means a program certified by the department of mental health involving residential care and structured, intensive treatment.

"Social setting detoxification" means a program in a supportive non-Hospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.

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 Mammography for the presence of occult breast cancer. Benefits will be provided according to the following guidelines:

1. A single baseline mammogram for women thirty-five to thirty-nine years of age.
2. A mammogram not less than once every two years for women forty to forty-nine years of age or more often for women with risk factors to breast cancer if recommended by her Physician.
3. A mammogram every year for women fifty and over;
4. A mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer.

"Low-dose mammography" means the x-ray examination of the breast, using equipment dedicated specifically for mammography including but not limited to the x-ray tub, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

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

Benefits for Prosthetic Device and Reconstructive Surgery

Benefits will be paid the same as any other Sickness for a Mastectomy and prosthetics device or reconstructive surgery necessary to restore symmetry incident to the Mastectomy when recommended by a Physician.

No time limit shall be imposed on an Insured Person for the receipt of prosthetic devices or reconstructive surgery while covered under the policy.

"**Mastectomy**" means the removal of all or part of the breast for medically necessary reasons as determined by a Physician.

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

Benefits for Cytologic Screening

Benefits will be paid the same as any other Sickness for a pelvic examination and cytologic screening (pap smear) for an Insured in accordance with the current American Cancer Society guidelines.

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 a colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic Insured Person in accordance with the current American Cancer Society guidelines.

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

Benefits for Prostate Screening

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer for an Insured in accordance with the current American Cancer Society guidelines.

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

Benefits for Second Opinion for Newly Diagnosed Cancer

Benefits will be paid the same as any other Sickness for a second opinion rendered by a Physician specializing in that specific cancer diagnosis area when an Insured with a newly diagnosed cancer is referred to such Physician specialist by his or her attending Physician.

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

Benefits for Clinical Trials for Cancer Treatment

Benefits will be paid the same as any other Sickness for Routine Patient Care Costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA) regardless of whether approved by the FDA for use in treating the Insured's particular condition for phase II, phase III or phase IV of a clinical trial and is undertaken for the purposes of the prevention, early detection, or treatment of cancer.

For Routine Patient Care Costs for phase II to be considered for payment, the clinical trials must meet all of the following criteria:

1. Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or Nation Cancer Institute Center; and
2. The Insured Person is enrolled in the clinical trial. Coverage for phase II clinical trials will not apply to Insured Persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

For Routine Patient Care Costs for phase III and phase IV to be considered for payment, the clinical trials must meet all of the following criteria:

1. The treatment is provided by (a) one of the National Institutes of Health (NIH); (b) an NIH Cooperative Group or Center; (c) the FDA in the form of an investigational new drug application; (d) the federal Departments of Veterans' Affairs or Defense; (e) an institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or (f) a qualified research entity that meets the criteria for NIH Center support grant eligibility.
2. The treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients.
3. There must be equal or superior noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.
4. Any entity seeking coverage for treatment, prevention, or early detection in a clinical trial approved by an institutional review board shall maintain and post electronically a list of the clinical trials meeting the above requirements. The list shall include: (a) the phase for which the trial is approved; (b) the entity approving the trial; (c) the particular disease; and (d) the number of participants in the trial. If electronic posting is not practical, the entity seeking coverage shall periodically provide a written list containing this information.

Providers participating in clinical trials shall obtain the Insured's informed consent for participation on the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to the Company upon request.

"Routine patient care costs" shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial including all items and services that are otherwise generally available to a qualified individual except: (a) the investigational item or service itself; (b) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (c) items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

The provisions of this section shall not be construed to affect compliance or coverage for off-label use of drugs not directly affected by this section.

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

Human Leukocyte Antigen Testing Benefit

Benefits will be paid the same as any other Sickness for Human Leukocyte Antigen Testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Benefits will be limited to one such testing per lifetime, not to exceed $75.00.

The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists. At the time of testing, the Insured being tested must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

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

Benefits for Osteoporosis

Benefits will paid the same as any other Sickness for services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a Physician for Insureds with a condition or medical history for which bone mass measurement is medically indicated. In determining whether testing or treatment is medically appropriate, due consideration will be given to peer reviewed medical literature.

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 a minimum of 48 hours for inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery. Post-discharge care will be payable for up to two visits by a registered professional nurse with experience in maternal and child health nursing or a Physician, one of which shall be in the home. A Physician shall determine the location and schedule of the post-discharge visits. Services shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization.

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

Benefits for Contraceptives

The Policyholder provides benefits for Contraceptives the same as any other Prescription Drug or device under this policy.

“Contraceptives” means all prescription drugs and devices approved by the Federal Food and Drug Administration for use as a contraceptive but shall exclude all drugs and devices that are intended to induce an abortion.

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

Benefits for Immunizations

Benefits will be paid the same as any other Sickness for immunizations of a child from birth to five years of age as provided by department of health regulations.

Benefits shall not be subject to any Deductible or Copayment limits.

Benefits for Phenylketonuria

Benefits will be paid the same as any other Sickness for formula and Low Protein Modified Food Products recommended by a Physician for the treatment of phenylketonuria (PKU) or any inherited disease of amino and organic acids for an Insured less than six (6) years of age. Benefits will not exceed $5,000 per policy year.

"Low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

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 Dependent Newborn Infants for hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

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

Benefits for Dental General Anesthesia

Benefits will be paid the same as any other Sickness for administration of general anesthesia and Hospital charges for dental care to a Dependent child under the age of five, an Insured who is severely disabled, or an Insured who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

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

Benefits for Autism Spectrum Disorder

Benefits will be paid the same as any other Sickness for Diagnosis and Treatment of Autism Spectrum Disorders for Insureds under the age of 19.

Benefits are limited to Medically Necessary treatment that is ordered by the Insured's treating licensed Physician or licensed psychologist, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, in accordance with a treatment plan. Upon request of the Company, the treatment plan shall include all elements necessary for the Company to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals. Except for Inpatient services, if an Insured is receiving Treatment for an Autism Disorder, the Company shall have the right to review the treatment plan not more than once every six months unless the Company and the Insured's treating Physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular Insured being treated for an Autism Spectrum Disorder and shall not apply to all Insureds being treated for Autism Spectrum Disorders by a Physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the Company.

"Treatment for Autism Spectrum Disorders" means care prescribed or ordered for an individual diagnosed with an ASD by a licensed physician or licensed psychologist, including equipment medically necessary for such care, pursuant to the powers granted under the licensed physician's or licensed psychologist's license, including but not limited to: Psychiatric Care; Psychological Care; Habilitative or Rehabilitative Care, including Applied Behavior Analysis therapy; Therapeutic Care; and Pharmacy care.

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorders" (ASD) means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an ASD.

"Habilitative or rehabilitative care" means a professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.

"Pharmacy Care" means medication used to address symptoms of an ASD prescribed by a licensed Physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the policy.

"Psychiatric Care" means the direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

"Psychological Care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic Care" means services provided by licensed speech therapists, occupational therapists, or physical therapists.

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

Benefits for Chiropractic Care

Benefits will be paid the same as any other Sickness for the chiropractic care delivered by a licensed chiropractor. Benefits will include initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder. Benefits will be provided for twenty-six (26) visits per policy year. In order to receive benefits for any additional visits, the Insured must notify the Company prior to receiving any additional visits. Review of Medical Necessity will be performed for any follow-up diagnostic tests or visits for treatment in excess of the initial twenty-six visits.

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

Benefits for Early Intervention Services for Children with Disabilities

Benefits will be paid the same as any other Sickness for Early Intervention Services for children from birth to the age of three (3) identified by the Part C early intervention system as eligible for services and when Early Intervention Services are delivered by an early intervention specialist who is a health care professional licensed by the state of Missouri and acts within the scope of their profession. Benefits will be limited to three-thousand dollars ($3,000) per each Insured child Per Policy Year.

"Early Intervention Services" means Medically Necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three (3) who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Early Intervention Services include services under an active Individualized Family Service Plan that enhances the functional ability without effecting a cure.

"Individualized Family Service Plan" means a written plan for providing Early Intervention Services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C Section 1436.

The Company shall be billed at the applicable Medicaid rate at the time the covered benefit is delivered and shall pay the Part C early intervention system at such rate for benefits covered by this mandate.

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 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 accidental bodily injury sustained, directly and independently of all other causes; treated by a Physician within 30 days after the date of accident and while the Insured Person is covered under this policy.

Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

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

MEDICAL EMERGENCY means the occurrence of a sudden and at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that immediate medical care is required, which may include, but shall not be limited to:

1) Death.
2) Placing the Insured's health in significant jeopardy.
3) Serious impairment of bodily functions.
4) Serious dysfunction of any body organ or part.
5) Inadequately controlled pain.
6) With respect to a pregnant woman, who is having contractions:
    a. that there is inadequate time to effect a safe transfer to another Hospital before delivery; or

b. that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

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

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

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

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

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

PRE-EXISTING CONDITION means any condition which is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

SICKNESS means sickness or disease of the Insured Person which causes loss 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.

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

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

Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to or related to 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. Biofeedback;
6. Circumcision;
7. Congenital conditions, except as specifically provided for Newborn or adopted Infants;

8. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
9. 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 as specifically provided in Benefits for Dental General Anesthesia or 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. Health spa or similar facilities; strengthening programs;
16. Unless coverage is elected by the Policyholder, hearing examinations; hearing aids; or cochlear implants; except as specifically provided in the policy; or other treatment for hearing defects and problems, except as specifically provided in Benefits for Newborn Hearing Screening or except as a result of an infection or Injury. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
17. Hirsutism; alopecia;
18. Hypnosis;
19. 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;
20. Injury caused by, contributed to, or resulting from the use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
21. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
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;
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; or when referred by the Student Health Center;
27. Participation in a riot or civil disorder; commission of or attempt to commit a felony;

28. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;
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 policy;
    b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in Benefits for Clinical Trial for Cancer Treatment;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
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 Benefits for Clinical Trial for Cancer Treatment;
32. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
33. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
34. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
35. 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;

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. Unless coverage is elected by the Policyholder, speech therapy; naturopathic services;
39. Supplies, except as specifically provided in the policy;
40. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
41. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
42. 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
43. Weight management, weight reduction, nutrition programs, treatment for obesity, (except surgery for morbid obesity), surgery for removal of excess skin or fat.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

FrontierMEDEX: Global Emergency Medical Assistance

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

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

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

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

Key Services include:

*Transfer of Insurance Information to Medical Providers

*Transfer of Medical Records

*Worldwide Medical and Dental Referrals

*Emergency Medical Evacuation

*Monitoring of Treatment

*Medication, Vaccine and Blood Transfers

*Dispatch of Doctors/Specialists

*Facilitation of Hospital Admission Payments

*Transportation After Stabilization

*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
*Emergency Travel Arrangements
*Continuous Updates to Family and Home Physician
*Replacement of Lost or Stolen Travel Documents
*Repatriation of Mortal Remains
*Transfer of Funds
*Translation Services

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

To access services please call:

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

(410) 453-6330 Collect outside the United States

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

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

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

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

Notice of Appeal Rights

Right to Internal Appeal

DEFINITIONS

For the purpose of the Notice of Appeal Rights, the following terms are defined as shown below:

Adverse Determination means:

1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy as an Insured Person;

3. Any concurrent, prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy; or
4. A rescission of coverage.

Authorized Representative means:

1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

Concurrent Review means Utilization Review conducted during a patient's Inpatient hospital stay or course of treatment.

Final Adverse Determination means an Adverse Determination involving a Covered Medical Expense that has been upheld by the Company, at the completion of the Company's internal appeal process or an Adverse Determination for which the internal appeals process has been deemed exhausted in accordance with this notice.

Grievance means a written compliant submitted by or on behalf of an Insured Person regarding the:

1. Availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review
2. Claims payment, handling or reimbursement for health care services; or
3. Matters pertaining to the contractual relationship between an Insured Person and a health carrier.

Prospective Review means Utilization Review performed prior to an admission or course of treatment.

Retrospective Review means Utilization Review of Medical Necessity conducted after services have been provided to a patient. Retrospective review does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

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

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, Concurrent Review, case management, discharge planning, or Retrospective Review.

INTERNAL APPEAL PROCESS

An Insured Person or an Authorized Representative may submit a written request for an Internal Review of a Grievance.

Upon receipt of the request for an Internal Review of a Grievance, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial 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.

The Customer Service Department can be contacted 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.

Within 10 working days after receipt of the Grievance, the Company shall provide acknowledgement of receipt of the Grievance and notice that the Insured Person or Authorized Representative is entitled to:

1. Contact the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) at any time.

Within 3 days after receipt of a Grievance involving an Adverse Determination, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

1. Contact the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) at any time.
2. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
3. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:

1. Any new or additional evidence considered by the Company in connection with the Adverse Determination;
2. Any new or additional rationale upon which the decision was based.

The Insured Person or Authorized Representative shall have 10 calendar days to respond to any new or additional evidence or rationale.

The company shall complete an investigation within 20 working days after receipt of the Grievance. If the investigation cannot be completed within 20 working days, the Insured Person or Authorized Representative will be notified in writing on or before the twentieth working day with the specific reasons for which additional time is needed for the investigation. The investigation shall then be completed within 30 working days thereafter.

Within 5 working days after the investigation has been completed, the Company shall notify the Insured or Authorized Representative in writing of the Company's decision regarding the Grievance and of the right to file an External Appeal with the DIFP.

The DIFP can be contacted at the following address and telephone number:

Missouri Department of Insurance, Financial Institutions and Professional Registration

Consumer Affairs Division

301 W. High Street, Room 830

Harry S. Truman State Office Building

Jefferson City, MO 65101

(800) 726 7390

www.insurance.mo.gov

consumeraffairs@insurance.mo.gov

Within 15 days after the investigation has been completed, the Company shall also notify the person who submitted the Grievance of the Company's resolution of said Grievance.

Time periods shall be calculated based on the date the Company receives the request for the Internal Review, without regard to whether all of the information necessary to make the determination accompanies the request.

If the Grievance involves an Adverse Determination, the written notice of Final Adverse Determination for the Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the Grievance, including the following:

a. the date of service;

b. the name health care provider; and

c. the claim amount;

3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:

a. the specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;

b. reference to the specific Policy provisions upon which the determination is based;

c. a statement that the Insured Person is entitled to received, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;

d. if applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;

e. if the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;

f. instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;

5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation; and

6. The Insured Person's right to bring a civil action in a court of competent jurisdiction.
7. Notice of the Insured Person's right to contact the Director's office or ombudsman's office for assistance with respect to any claim, Grievance or appeal at any time.

Expedited Internal Review (EIR) of a Grievance

The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of a Grievance involving a situation where the time frame of the standard first and/or second level appeals would seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function:

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Insured Person has been notified of the final determination.

The Insured Person or the Authorized Representative shall be notified orally of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request. Written confirmation of the decision will be provided within three (3) working days of providing notification of the determination.

At the same time an Insured Person or an Authorized Representative files an EIR request, the Insured Person or the Authorized Representative may file:

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function.

EXTERNAL INDEPENDENT REVIEW

An Insured Person or Authorized Representative may file a Grievance with the Director of the DIFP when the Insured has received an Adverse Determination or Final Adverse Determination from the Company. The Insured Person or Authorized Representative may submit a request for an External Independent Review without exhausting all remedies available under the Company's Grievance process.

The DIFP can be contacted at the following address and telephone number:

Missouri Department of Insurance, Financial Institutions and Professional Registration

Consumer Affairs Division

301 W. High Street, Room 830

Harry S. Truman State Office Building

Jefferson City, MO 65101

(800) 726 7390

www.insurance.mo.gov

consumeraffairs@insurance.mo.gov

I. Standard External Review Process

1. After the Grievance is received, the Director shall attempt to resolve as a consumer complaint and resolve the issue with the Company. If the Director determines the issue cannot be resolved, the Director shall:

a. Refer the unresolved Grievance to an Independent Review Organization from the Director's approved list.

b. Provide the IRO, Insured Person or their Authorized Representative, or the Company with copies of all medical records or any other relevant documents which the Division has received from any party.

2. The Insured Person, Authorized Representative, or the Company may submit additional information to the DIFP, which the DIFP will forward to the IRO for consideration when conducting the review. If the Insured Person, Authorized Representative, or the Company has information which contradicts information already provided to IRO, then this information must be provided as additional information. All additional information should be received by the DIFP within 15 working days from the date the DIFP mailed that party copies of the information provided to the IRO
3. If the IRO shall request from the DIFP additional information needed and the DIFP shall gather the requested information from the Company, Insured Person or, if applicable, the Authorized Representative and provide it to the IRO. If the Director is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.
4. Within 20 days after receipt of the request for external review, the IRO shall provide, to the Director, its opinion to uphold or reverse the Adverse Determination or Final Adverse Determination. Under exceptional circumstances, if the IRO requires additional time to complete its review, the IRO will request in writing from the Director an extension in the time to process the review, which will not exceed 5 calendar days.
5. After the Director receives the IRO's decision, the Director shall, within 25 calendar days of receiving the IRO's opinion, provide written notice of the Director's decision to uphold or reverse the Adverse Determination or Final Adverse Determination to the, the Company, the Insured Person and, if applicable, the Authorized Representative. In no event shall the time between the date the IRO receives the request for external review and the date the Insured and the Company are notified of the Director's decision be longer than 45 days.
6. The Director's decision shall be binding upon the Insured Person and the Company.

Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

II. Expedited External Review (EER) Process

1. The Insured Person or an Authorized Representative may make a request for an Expedited External Review (EER) with the Director at the time the Insured Person receives:

(i) an Adverse Determination involving a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

(ii) an Adverse Determination involving 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.

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.

2. As expeditiously as possible after receipt of the request for EER by the IRO, the IRO must issue its opinion as to whether the Adverse Determination should be upheld or reversed and submit its opinion to the Director.
3. As expeditiously as possible, but within no more than 72 hours after receipt of the qualifying EER request, the Director shall then issue a decision. If the notice is not in writing, the Director will provide the written decision within 48 hours after the date of the notice of determination.

4. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

III. Experimental or Investigational Treatment External Review Process

1. If a request for external review of an Adverse Determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the following additional requirements must be met.
2. The IRO will complete a preliminary review to determine that:

a. the recommended healthcare service or treatment subject to the Adverse Determination or Final Adverse Determination is a covered benefit under the Policy; and

b. the recommended healthcare service or treatment subject to the Adverse Determination or Final Adverse Determination is not explicitly listed as an excluded benefit under the Policy.

3. The request for external review of an Adverse Determination involving a denial of coverage based on the Company's determination that the health care service or treatment recommended or requested is experimental or investigational must include a certification from the Insured Person's Physician stating:

a. Standard health care services or treatments have not been effective in improving the condition of the Insured Person, or

b. Standard health care services or treatments are not medically appropriate for the Insured Person; or

c. There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment; and

d. The request for external review of an Adverse Determination involving the denial of coverage based on a determination that the requested treatment is experimental or investigational shall also include documentation that:

i. The Insured Person's treating Physician has recommended a health care service or treatment that the Physician certifies, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion than any available standard health care services or treatments; or

ii. That the Insured Person's treating Physician, who is a licensed, board-certified, or board-eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care service or treatment.

4. When conducting the external review of an Adverse Determination involving a denial of coverage based on a determination the health care service or treatment is experimental or investigational, the IRO shall select 1 or more clinical peers who must be Physicians or other health care professionals who meet minimum qualifications and through clinical experience in the past 3 years are experts in the treatment of the Insured's condition and knowledgeable about the recommended or requested health care service or treatment.
5. Each clinical reviewer shall provide written opinion to the IRO to uphold or reverse the Adverse Determination or Final Adverse Determination. The IRO shall provide the opinions to the Director who shall then issue the decision to either uphold or

reverse the Adverse Determination or Final Adverse Determination with the same time frames for the standard and expedited external review procedures.

6. Upon receipt of the Director's notice of a decision reversing an Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

An External Review decision is binding on the Company except to the extent the Company has other remedies available under state law. An External Review decision is binding on the Insured Person except to the extent the Insured Person has other remedies available under applicable federal or state law. An Insured Person or an Authorized Representative may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Insured Person has already received an External Review decision.

Where to Send External Review Requests

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

Missouri Department of Insurance, Financial Institutions and Professional Registration

Consumer Affairs Division

301 W. High Street, Room 830

Harry S. Truman State Office Building

Jefferson City, MO 65101

(800) 726 7390

www.insurance.mo.gov

consumeraffairs@insurance.mo.gov

Questions Regarding Appeal Rights

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

Online Access to Account Information

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

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

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

ID Cards

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

UnitedHealth Allies

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

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Student Health Service for treatment, or when not in school, to their Physician or Hospital.
2) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the university under which the student is insured. A Company claim form is not required for filing a claim.

   A written notice of claim must be submitted to the address below within 90 days after expense is incurred, or as soon thereafter as reasonably possible. Upon receipt of a notice of claim, the Company will furnish the Insured the necessary forms for filing proof of loss. If the person making claim does not receive the necessary claim forms before the expiration of 15 days after first requesting such forms, the Insured shall be deemed to have complied with the requirements as to the proof of loss upon submitting to the Company within 90 days written proof covering the occurrence, character and extent of the loss for which claim is made.
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.
4) The Insured's failure to give notice within such time will not invalidate nor reduce any claim if it is shown that notice was given as soon as was reasonably possible. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700
customerservice@uhcsr.com
claims@uhcsr.com

Sales/Marketing Services:

UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
1-800-237-0903
E-Mail: info@uhcsr.com

Please keep this 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: 2013-722-1

Lincoln University

v3