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## 2015–2016 Student Injury and Sickness Insurance Plan

*Designed Especially for the Students of*



**THE OHIO STATE UNIVERSITY**

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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 1-844-206-0374 or visiting us at [www.uhcsr.com/osu](http://www.uhcsr.com/osu).

## Eligibility and Enrollment

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### Domestic Plan:

All registered Domestic Students enrolled in a degree program and enrolled in at least six (6) credit hours for undergraduates, at least four (4) credit hours for graduate and professional students and at least three (3) credit hours for post-candidacy doctoral students are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished by the published deadline of their first term of enrollment.

### International Plan:

International Students are required to enroll in Student Health Insurance as a condition of their enrollment at The Ohio State University regardless of credit hours. International students cannot waive coverage unless they are fully sponsored by their government and automatically have healthcare coverage insurance provided as a participant in the program; a dependent of a U.S. based employee plan; or the student is covered under a US-based health insurance policy as a US-based employee, or have permanent U.S. residence status. The plans must meet minimum coverage requirements comparable to the Student Health Insurance being offered by The Ohio State University. To request a waiver, submit a Petition to Waive located at <http://www.shi.osu.edu> under Important Forms.

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 legal spouse or Domestic Partner and dependent children under 26 years of age. Eligible students who do enroll may also cover a dependent child until the age of twenty-eight (28) years under certain circumstances as defined on page 24, under the definition of a Dependent. See the Definitions section of the Brochure for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Students who do not meet the minimum credit hour requirements are not eligible to purchase the Student Health Insurance.

Students meeting the eligibility requirements are automatically enrolled in the Student Health Insurance Plan each year.

Exceptions apply to enrolled students taking one of the approved exception course numbers representing co-ops, internship, study abroad, and thesis or dissertation research. These students will be automatically charged and the health insurance premium will be included in their fees regardless of credit hours unless the student waives coverage.

### The following courses are excluded from being applied towards the minimum credit hour requirement:

- Courses taken in a Non-degree status. The following programs or plans are considered non-degree:
  - Graduate Non-degree,
  - Graduate Visitor,
  - Undergraduate Non-degree,
  - Undergraduate Visitor,
  - Undergraduate Academy,
  - Law Non-degree, and
  - Law Casual.
  
- Students may petition for an exception if the course is a pre-requisite for entrance into a degree status program of study, and if the course is graduate level, the student has a current application on file with the Graduate School.

- Courses designated as Continuing Education
- Courses taken as Audit
- Distance Learning courses (as denoted by “mode of instruction”) in absence of eligible on campus courses. Students taking Distance learning courses exclusively will not default into Student Health Insurance coverage, but may petition to enroll in the plan.

Eligible students who do not wish to enroll must waive coverage by providing proof of adequate insurance coverage by the published deadline of their first term of enrollment. This process must be completed online at your Student Center at [www.buckeyelink.osu.edu](http://www.buckeyelink.osu.edu).

### **Interim Coverage**

Students enrolling at The Ohio State University for the first time and meeting the following criteria are eligible to purchase interim insurance in order to have coverage in advance of the effective date of the new term of enrollment:

- International student
- Graduate or professional student
- Undergraduate student required to arrive early to campus by an Ohio State program.
- Undergraduate student whose personal insurance expires between July 22, 2015 and August 18, 2015.

Interim insurance provides up to 4 weeks of extended coverage. A pro-rated, weekly premium must be paid to the Office of The University Bursar for this coverage in addition to the standard rate for the upcoming enrolled term.

### **Refund Policy**

Coverage will be terminated and any premium will be refunded on the student's account up through the 2nd Friday of the school term if the student drops below eligible credit hours or withdraws from classes. For students withdrawing from the University after the second Friday of the school term, health insurance premiums will not be refunded. Exception: A covered person entering the armed forces of any country will not be covered under the policy as of the date of such entry. In this case, a pro-rata refund will be made for any such person and any covered dependents upon written request received by The Ohio State University within 90 days of withdrawal from school.

### **Effective and Termination Dates**

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The Master Policy on file at the school becomes effective at 12:01 a.m., July 22, 2015. 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 15, 2016. 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, or if eligibility requirements are not meet.

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

## Student Health Care Services

This section includes a description of the benefits available to you and your eligible dependents when you receive services at the Wilce Student Health Center, Counseling and Consultation Service at the Younkin Success Center, and the OSU Optometry Clinics. These benefits are self-funded by The Ohio State University and are not underwritten or administered by UnitedHealthcare Insurance Company.

The Wilce Student Health Center is the University's on-campus, outpatient health facility, open Monday – Thursday 8:00 am to 6:00 pm, Friday 8:00 am to 5:00 pm and some Saturday hours. To schedule an appointment or speak with an Advice Nurse, call Student Health Services at **(614) 292-4321**. In the event of an emergency, call **911** or go to the nearest emergency room.

<b>Ohio State University Student Health Services</b>	<p><b>Covered Medical Services</b> provided by Student Health Services at the Student Health Center are covered by the <b>University at the Tier 1 benefit levels</b>.</p> <p>Services at the Wilce Student Health Center are subject to availability and changes in scope of services offered to students. Unlimited Prescription Medicine Expenses when dispensed by a Student Health Services provider are covered by the University at Student Health Services.</p> <p>Services provided by Student Health Services for expenses related to a motor vehicle accident (MVA) are billable to UnitedHealthcare <b>StudentResources</b>. <b>Covered Medical Expenses</b> will be payable at the TIER 2 benefit levels as specified below for the applicable service being provided.</p>
<b>Deductibles</b>	<p>There is no annual Deductible applied to TIER 1 Covered Services rendered by Student Health Services.</p>

<b>Tier 1 Student Health Services at the Wilce Student Health Center</b>
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<b>Surgical Expense Outpatient</b>	<b>Covered Medical Expenses</b> for charges for surgical services, performed by a Physician.
	<b>Covered Medical Expenses</b> are payable at <b>100%</b> of the negotiated charge.
<b>Physician's Office Visit Expense</b>	<b>Covered Medical Expenses</b> are payable at <b>100%</b> of the negotiated charge.
<b>Diagnostic Laboratory and X-Ray Expense</b>	<b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> of the negotiated charge.
<b>Durable Medical and Surgical Equipment Expense</b>	<b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> of the negotiated charge. (when in stock and ordered by a Student Health Services provider)
<b>Physical Therapy Expense</b>	<b>Covered Medical Expenses</b> for physical therapy are payable as follows when provided by a licensed physical therapist.
	<b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> of the negotiated charge.
<b>Nutritional Therapy</b>	<b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> of the negotiated charge.
<b>Preventative Care Services</b>	<b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> of the negotiated charge Selected Academic & Travel Related Immunizations and screening titers (when required for OSU Academic programs or travel) covered at <b>50%</b> of the negotiated charge. Annual sexual health screening limited to one of each of the following tests based on age and patient history: Chlamydia, Gonorrhea, HIV, Syphilis.
<b>Allergy Testing, Treatment and Injections Services</b>	<b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> serum not included.

<b>Consultant Expense</b>	<p><b>Covered Medical Expenses</b> include the expenses for the services of a consultant. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> of the negotiated charge.</p>
<b>Mental Health Services at The Ohio State University Counseling and Consultation Service</b>	
<b>Outpatient Expense</b>	<p><b>Covered Medical Expenses</b> for outpatient treatment of a mental health condition.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> of the negotiated charge.</p>
<b>Alcoholism and Drug Addiction Treatment (Ohio State University Counseling and Consultation Service)</b>	
<b>Outpatient Expense</b>	<p><b>Covered Medical Expenses</b> for outpatient treatment of Alcoholism and Drug Addiction conditions.</p> <p><b>Covered Medical Expenses</b> are payable as follows: <b>100%</b> of the negotiated charge.</p>
<b>Routine Vision Care Evaluation Expense at the Wilce Student Health Center or the OSU College of Optometry (Adult)</b>	<p>Benefits include charges for any service shown below, which is furnished by a legally qualified ophthalmologist or optometrist.</p> <p>*Routine Eye Evaluation Expenses: Charges for a complete eye evaluation that includes refraction.</p> <p>A routine eye evaluation does not include charges for a contact lens evaluation.</p> <p>*Contact Lens Evaluation Expenses: Charges for an eye evaluation performed to determine an existing contact lens wearer's prescription.</p> <p>Benefits are limited to one routine eye evaluation and one contact lens evaluation per Policy Year.</p> <p><b>Limitations</b></p> <p>The following limitations apply: No benefits will be payable for a charge which is:</p> <ul style="list-style-type: none"> <li>• For any eye evaluation to diagnose or treat a disease or injury.</li> <li>• For drugs or medicines.</li> <li>• For a vision care service that is a Covered Medical Expense in whole or in part, under any other part of this Plan, or under any other group plan.</li> <li>• For a vision care service for which a benefit is provided in whole or in part, under any workers' compensation law or any other law of like purpose.</li> <li>• For special procedures. This means things such as orthoptics or vision training.</li> <li>• For any vision care supply.</li> <li>• For an eye evaluation which is required by an employer as a condition of employment, or an employer is required to provide under labor agreement, or is required by any law of a government.</li> <li>• For a service received while the person is not a covered person.</li> <li>• For a service which does not meet professionally accepted standards.</li> <li>• For any evaluation given while the person is confined in a hospital or other facility for medical care.</li> </ul> <p><b>Covered Medical Expenses</b> will be payable as follows: Following a <b>\$15</b> copay, <b>100%</b> of the negotiated charge without any maximum allowance <b>*\$20</b> copay for annual contact lens evaluation. Service must be performed on the same day as annual vision evaluation to be covered.</p>
<b>Eyewear or Contact Lens Allowance "Students Only"</b>	<p>Benefits include an allowance of up to <b>\$100</b> per policy year toward the combined cost of prescription eyewear and/or contact lenses.</p>

<b>Pediatric Vision Care Evaluation Expense</b>	<b>Covered Medical Expenses</b> include routine vision evaluation (including Refraction & Glaucoma Testing), non-cosmetic eyeglass frames, prescription lenses or prescription contact lenses (not both). Benefits are provided to covered students thru age 18. One pair of glasses (lenses and frames) per Policy Year.  <b>Covered Medical Expenses</b> will be payable as follows: <b>100%</b> of the negotiated charge without any maximum allowance. <b>Note: Only students thru age 18 may be seen at Wilce Student Health Center.</b>
<b>Prescription Coverage</b>	Services at the Wilce Student Health Services are subject to availability and changes in scope of services offered to students. Unlimited Prescription Medicine Expenses are covered by the University at Wilce Student Health Services and are not billed to UnitedHealthcare <b>StudentResources</b> for students and any insured dependents.

### **Extension of Benefits after Termination**

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

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

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

### **Pre-Admission Notification**

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

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

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

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

## **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:

- OSU Health Plan Network
- UnitedHealthcare Options (Tier 2) providers outside Franklin County.
- UnitedHealthcare Options PPO United Behavioral Health (UBH) (Tier2) providers outside Franklin County.

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 OSU at 1-614-292-4700 or HealthSmart at 1-844-206-0374 and/or by asking the provider when making an appointment for services.

OSU Health Plan Network: <https://osuhealthplan.com/network-access-search>

UnitedHealthcare Options: [www.uhcsr.com/osu](http://www.uhcsr.com/osu)

UnitedHealthcare Options PPO United Behavioral Health (UBH): United Behavioral Health Providers

“**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 OSU Health Plan Network facilities in Franklin County and UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities outside of Franklin County. Call OSU Health Plan Network at 1-614-292-4700 or HealthSmart at 1-844-206-0374 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 OSU Health Plan Network and 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.



## Schedule of Medical Expense Benefits

Metallic Level Platinum	
Injury and Sickness Benefits	
No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)	
Maximum Benefit	No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)
Deductible Preferred Providers (Tier 2)	\$100 (Per Insured Person, Per Policy Year)
Deductible Preferred Providers (Tier 2)	\$300 (For all Insureds in a Family, Per Policy Year)
Deductible In-Network Providers (Tier 3)	\$500 (Per Insured Person, Per Policy Year)
Deductible In-Network Providers (Tier 3)	\$1,500 (For all Insureds in a Family, Per Policy Year)
Deductible Out-of-Network (Tier 4)	\$500 (Per Insured Person, Per Policy Year)
<b>(Combined In-Network and Out-of-Network Maximum Deductible is \$500 Per Insured Person, Per Policy Year)</b>	
Deductible Out-of-Network (Tier 4)	\$1,500 (For all Insureds in a Family, Per Policy Year)
<b>(Combined In-Network and Out-of-Network Maximum Deductible is \$1,500 For all Insureds in a Family, Per Policy Year)</b>	
Coinsurance Preferred Providers (Tier 2)	90% except as noted below
Coinsurance In-Network Providers (Tier 3)	60% except as noted below
Coinsurance Out-of-Network (Tier 4)	60% except as noted below
Out-of-Pocket Maximum Preferred Providers (Tier 2)	\$2,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Providers (Tier 2)	\$4,000 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum In-Network Providers (Tier 3)	\$6,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum In-Network Providers (Tier 3)	\$12,000 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network (Tier 4)	\$6,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network (Tier 4)	\$12,000 (For all Insureds in a Family, Per Policy Year)
The Preferred Providers for this plan are OSU Health Plan Network in Franklin County and UnitedHealthcare Options PPO outside Franklin County.	
If care is received from a Preferred Provider (OSU Health Plan Network in Franklin County and UnitedHealthcare Options PPO outside Franklin County) any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If care is received within the Network (UnitedHealthcare Options PPO inside Franklin County) any Covered Medical Expenses will be paid at the In-Network level of benefits. If the Covered Medical Expense is incurred for Emergency Services when 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.	
When treatment is rendered outside the United States, Covered Medical Expenses will be paid at the Preferred Provider (Tier 2) level of benefits.	
<b>Student Health Center Benefit:</b> The exclusion will be waived and benefits will be paid at the Preferred Provider (Tier 2) level of benefits when treatment is rendered at the Student Health Center for motor vehicle injury.	
The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.	
<b>Out-of-Pocket Maximum:</b> After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Covered Medical Expenses used to satisfy any of the Out-of-Pocket Maximums will be applied to the Preferred Provider, In-Network Provider and Out-of-Network Out-of-Pocket Maximums. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.	
Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider In-Network and Out-of-Network unless otherwise specifically stated. <b>Please refer to the Medical Expense Benefits – Injury and Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:</b>	

<b>Inpatient</b>	<b>Preferred Provider (Tier 2) OSU Health Plan in Franklin County and UHC Network outside of Franklin County</b>	<b>In-Network (Tier 3) UHC Network in Franklin County</b>	<b>Out-of-Network (Tier 4)</b>
<b>Room and Board Expense</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Intensive Care</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Hospital Miscellaneous Expenses</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Routine Newborn Care</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Surgery</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.	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Assistant Surgeon Fees</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Anesthetist Services</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Registered Nurse's Services</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Physician's Visits</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Pre-admission Testing</b> Payable within 7 working days prior to admission.	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges

<b>Outpatient</b>	<b>Preferred Provider (Tier 2) OSU Health Plan in Franklin County and UHC Network outside of Franklin County</b>	<b>In-Network (Tier 3) UHC Network in Franklin County</b>	<b>Out-of-Network (Tier 4)</b>
<b>Surgery</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.	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Day Surgery Miscellaneous</b> Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Assistant Surgeon Fees</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Anesthetist Services</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges

<b>Outpatient</b>	<b>Preferred Provider (Tier 2)</b> OSU Health Plan in Franklin County and UHC Network outside of Franklin County	<b>In-Network (Tier 3)</b> UHC Network in Franklin County	<b>Out-of-Network (Tier 4)</b>
<b>Physician's Visits</b>	100% of Preferred Allowance \$15 Copay per visit	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Physiotherapy</b> Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Medical Emergency Expenses</b> Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. The Copay/per visit Deductible will be waived if admitted to the Hospital.	100% of Preferred Allowance for the first \$500, then 90% thereafter \$100 Copay per visit	100% of Preferred Allowance for the first \$500, then 90% thereafter \$100 Copay per visit	100% of Usual and Customary Charges for the first \$500, then 90% thereafter \$100 Deductible per visit
<b>Diagnostic X-ray Services</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Radiation Therapy</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Laboratory Procedures</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Tests &amp; Procedures</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Injections</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Chemotherapy</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Prescription Drugs</b> Minimum cost to the insured is \$10 or the cost of the drug, whichever is less. <b>Birth Control benefit determination, please review the public document at <a href="http://www.unitedhealthcareonline.com">www.unitedhealthcareonline.com</a></b>	HealthSmart Rx 90% Coinsurance per prescription for generic drugs 80% Coinsurance per prescription for brand name 50% Coinsurance per prescription for non-formulary up to a 31 day supply per prescription		90% Coinsurance per prescription for generic drugs 50% Coinsurance per prescription for brand name

<b>Other</b>	<b>Preferred Provider (Tier 2)</b> OSU Health Plan in Franklin County and UHC Network outside of Franklin County	<b>In-Network (Tier 3)</b> UHC Network in Franklin County	<b>Out-of-Network (Tier 4)</b>
<b>Ambulance Services</b>	90% of Preferred Allowance	90% of Preferred Allowance	90% of Usual and Customary Charges
<b>Durable Medical Equipment</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Consultant Physician Fees</b>	100% of Preferred Allowance \$15 Copay per visit	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Dental Treatment</b> Benefits paid on Injury to Sound, Natural Teeth only.	90% of Preferred Allowance	90% of Preferred Allowance	90% of Actual Charges

<b>Other</b>	<b>Preferred Provider (Tier 2)</b> OSU Health Plan in Franklin County and UHC Network outside of Franklin County	<b>In-Network (Tier 3)</b> UHC Network in Franklin County	<b>Out-of-Network (Tier 4)</b>
<b>Mental Illness Treatment</b> See also Benefits for Biologically Based Mental Illness. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered. See Preferred Provider section on page 6 for information on covered Inpatient facilities.	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Substance Use Disorder Treatment</b> Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered. See Preferred Provider section on page 6 for information on covered Inpatient facilities.	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Maternity</b> See also Benefits for Maternity Follow- Up Care.	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Complications of Pregnancy</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Elective Abortion</b> Graduate Associates or Fellows receiving a premium subsidy from The Ohio State University are not eligible for this benefit.	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Preventive Care Services</b> No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider or In-Network Provider. Information regarding preventive services may be obtained from Customer Service at 1-844-206-0374 and at the following websites: <a href="http://www.uspreventiveservicestaskforce.org">http://www.uspreventiveservicestaskforce.org</a> and <a href="http://www.hrsa.gov/womensguidelines">http://www.hrsa.gov/womensguidelines</a>	100% of Preferred Allowance	100% of Preferred Allowance	60% of Usual and Customary Charges
<b>Reconstructive Breast Surgery Following Mastectomy</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Diabetes Services</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Home Health Care</b> Maximum 100 Visits per Policy Year/ Additional 250 visits maximum per Policy Year for Private Duty Nursing.	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Hospice Care</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Inpatient Rehabilitation Facility</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Skilled Nursing Facility</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges

<b>Other</b>	<b>Preferred Provider (Tier 2)</b> OSU Health Plan in Franklin County and UHC Network outside of Franklin County	<b>In-Network (Tier 3)</b> UHC Network in Franklin County	<b>Out-of-Network (Tier 4)</b>
<b>Urgent Care Center</b>	100% of Preferred Allowance \$25 Copay per visit	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Hospital Outpatient Facility or Clinic</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Approved Clinical Trials</b> See also Benefits for Cancer Clinical Trials.	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Transplantation Services</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Medical Supplies</b> Benefits are limited to a 31-day supply per purchase.	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Ostomy Supplies</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Wigs</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Cochlear Implant Expense</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Human Organ Transplant – Donor Search</b> \$30,000 Maximum	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Human Organ Transplant – Lodging and Transportation</b> \$10,000 Maximum	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Acupuncture</b>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Sexual Reassignment Surgery</b> Cosmetic surgery, procedures and drugs are not covered even if related to sexual reassignment. Benefit determination of specific services; please review the public document at: <a href="#">Sexual Reassignment Surgery Coverage Determination Guideline</a>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider (Tier 2) OSU Health Plan in Franklin County and UHC Network outside of Franklin County	In-Network (Tier 3) UHC Network in Franklin County	Out-of-Network (Tier 4)
<p><b>Non-Prescription Enteral Formula Covered Medical Expenses</b> include charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by:</p> <ul style="list-style-type: none"> <li>• Crohn's Disease,</li> <li>• ulcerative colitis,</li> <li>• gastroesophageal reflux,</li> <li>• gastrointestinal motility,</li> <li>• chronic intestinal pseudo obstruction, and</li> <li>• inherited diseases of amino acids and organic acids.</li> </ul> <p>Covered Medical Expenses for inherited diseases of: amino acids, and organic acids, will also include food products modified to be low protein.</p>	90% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<p><b>Routine Eye Exam</b> \$50 maximum per Policy Year except as provided for in Pediatric Vision benefits.</p>	100% of Preferred Allowance \$15 Copay per visit	100% of Preferred Allowance \$15 Copay per visit	100% of Usual and Customary Charges \$15 Deductible per visit

## HealthSmart Rx Prescription Drug Expense Benefit

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### Network Prescription Drug Expense Benefit

The Prescription Drug Program is available through HealthSmart Rx.

After the insured pays 10% for each 31-day supply for generic drug, 20% for each 31-day supply for a brand name drug or 50% for each 31-day supply for brand name with a generic equivalent drug or the Expenses incurred for the balance of prescription drugs will be reimbursed at 100%. Minimum cost to the insured is \$10 or the cost of the drug, whichever is less. Prescriptions must be filled at a participating pharmacy with HealthSmart Rx Pharmacy. Insured Persons will use their student health insurance ID card to show the pharmacy proof of coverage. If a Prescription needs to be filled prior to receiving an ID card, reimbursement will be made for a covered prescription upon a completed and submitted Prescription Drug claim form.

**Expenses incurred for the following are excluded under the Plan:** fertility medications; legend vitamins or food supplements; except as provided in the policy; immunization agents and vaccines, except as provided in the policy; biological sera; blood plasma; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed at a Hospital or rest home. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: (a) the American Medical Association Drug Evaluations; (b) the American Hospital Formulary Service Drug Information; (c) the United States Pharmacopoeia Drug Information; or (d) it is recommended by a clinical study or review article in a major peer-reviewed professional journal. However, Covered Medical Expenses do not include experimental or investigational drugs, or any drug, which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

To locate a participating pharmacy, call HealthSmart Rx Pharmacy at 1-800-681-6912 or create an account at:

<https://healthsmart.rxportal.mycatamaranrx.com/rxclaim/portal/preLogin>.

When prescriptions are filled at pharmacies outside the HealthSmart RX network, the Insured must pay for the prescriptions out-of-pocket and submit the receipts for reimbursement to HealthSmart Rx, Inc., 3320 West Market St., Fairlawn, OH 44333.

See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.

### Medical Expense Benefits – Injury and Sickness

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This section describes Covered Medical Expenses for which benefits are available in the Schedule of Benefits.

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance, Copayment or per service Deductible amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

**ESSENTIAL HEALTH BENEFITS:** The following benefits are considered Essential Health Benefits.

#### Inpatient

1. **Room and Board Expense.**  
Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.
2. **Intensive Care.**  
If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**

When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

Benefits will be paid for services and supplies such as:

- The cost of the operating room.
- Laboratory tests.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. **Routine Newborn Care.**

While Hospital Confined and routine nursery care provided immediately after birth.

Benefits will be paid for an inpatient stay of at least:

- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.

5. **Surgery (Inpatient).**

Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**

Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**

Registered Nurse's services which are all of the following:

- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.

9. **Physician's Visits (Inpatient).**

Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

10. **Pre-admission Testing.**

Benefits are limited to routine tests such as:

- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the policy, major diagnostic procedures such as those listed below will be paid under the "Hospital Miscellaneous" benefit:

- CT scans.
- NMR's.
- Blood chemistries.



## **Outpatient**

11. **Surgery (Outpatient).**  
Physician's fees for outpatient surgery.
12. **Day Surgery Miscellaneous (Outpatient).**  
Facility charge and the charge for services and supplies in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.
13. **Assistant Surgeon Fees (Outpatient).**  
Assistant Surgeon Fees in connection with outpatient surgery.
14. **Anesthetist Services (Outpatient).**  
Professional services administered in connection with outpatient surgery.
15. **Physician's Visits (Outpatient).**  
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery or Physiotherapy.  
  
Physician's Visits for preventive care are provided as specified under Preventive Care Services.
16. **Physiotherapy (Outpatient).**  
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
  - Physical therapy.
  - Occupational therapy.
  - Cardiac rehabilitation therapy.
  - Manipulative treatment.
  - Massage therapy.
  - Speech therapy. Other than as provided for Habilitative Services, 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.
17. **Medical Emergency Expenses (Outpatient).**  
Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies and:
  - X-rays.
  - Laboratory procedures.
  - Tests and procedures.
  - Injections.
  - Attending physician charges.  
All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. **Diagnostic X-ray Services (Outpatient).**  
Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
19. **Radiation Therapy (Outpatient).**  
See Schedule of Benefits.
20. **Laboratory Procedures (Outpatient).**  
Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

21. **Tests and Procedures (Outpatient).**

Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:

- Physician's Visits.
- Physiotherapy.
- X-rays.
- Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:

- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.

Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. **Injections (Outpatient).**

When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy (Outpatient).**

See Schedule of Benefits.

24. **Prescription Drugs (Outpatient).**

See Schedule of Benefits.

**Other**

25. **Ambulance Services.**

See Schedule of Benefits.

26. **Durable Medical Equipment.**

Durable Medical Equipment must be all of the following:

- Provided or prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Primarily and customarily used to serve a medical purpose.
- Can withstand repeated use.
- Generally is not useful to a person in the absence of Injury or Sickness.
- Not consumable or disposable except as needed for the effective use of covered durable medical equipment.

For the purposes of this benefit, the following are considered durable medical equipment:

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part including custom made shoe inserts.

If more than one piece of equipment or device can meet the Insured's functional needs, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

27. **Consultant Physician Fees.**

Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**

Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Sound, Natural Teeth.
- Facility charges for outpatient services if the Insured's medical condition or a dental procedure requires a Hospital setting to ensure the safety of the Insured.
- X-rays, supplies, appliances and all associated Covered Medical Expenses, including Hospital facility charges and anesthesia for transplant preparation, initiation of immunosuppressives, direct treatment of acute traumatic Injury, cancer or cleft palate.

Benefits for accidental dental Injury include, but are not limited to:

- Oral examination.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. Pediatric dental benefits are provided in the Pediatric Dental Services provision.

29. **Mental Illness Treatment.**

Benefits will be paid for services received:

- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

See also Benefits for Biologically Based Mental Illness.

30. **Substance Use Disorder Treatment.**

Benefits will be paid for services received:

- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

31. **Maternity.**

Same as any other Sickness.

Benefits will be paid for an inpatient stay of at least:

- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.

See also Benefits for Maternity Follow-Up Care.

32. **Complications of Pregnancy.**

Same as any other Sickness.

**33. 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:

- 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*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- 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*.  
With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.  
<http://www.uspreventiveservicestaskforce.org> and <http://www.hrsa.gov/womensguidelines>

**34. Reconstructive Breast Surgery Following Mastectomy.**

Same as any other Sickness and in connection with a covered mastectomy.

Benefits include:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and physical complications of mastectomy, including lymphedemas.

**35. Diabetes Services.**

Same as any other Sickness in connection with the treatment of diabetes.

Benefits will be paid for Medically Necessary:

- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- 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.

**36. Home Health Care.**

Services received from a licensed home health agency that are:

- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person's home.
- Pursuant to a home health plan.

Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.

Benefits also include Private Duty Nursing services only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. Private duty nursing services includes teaching and monitoring of complex care skills such as a tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care.

For the purposes of this benefit “Private Duty Nursing” means skilled nursing service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.) or licensed practical nurse (L.P.N). Private duty nursing is shift nursing of eight hours or greater per day and does not include nursing care of less than eight hours per day. Private duty nursing does not include Custodial Care services.

**37. Hospice Care.**

When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.

Hospice care includes:

- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.

**38. Inpatient Rehabilitation Facility.**

Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

Benefits include a day rehabilitation therapy program for Insureds who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day at a Day Hospital. Day rehabilitation program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two therapy services must be provided for this program to be a Covered Medical Expense.

**39. Skilled Nursing Facility.**

Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:

- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

**40. Urgent Care Center.**

Benefits are limited to:

- The facility or clinic fee billed by the Urgent Care Center.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

**41. Hospital Outpatient Facility or Clinic.**

Benefits are limited to:

- The facility or clinic fee billed by the Hospital.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

**42. Approved Clinical Trials.**

Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include:

- The experimental or investigational item, device or service, itself.
- 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.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

See also Benefits for Cancer Clinical Trials.

**43. Transplantation Services.**

Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under this policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this policy to be primary.

No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.

Travel expenses are not covered. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

**44. Medical Supplies.**

Medical supplies must meet all of the following criteria:

- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

Benefits are limited to a 31-day supply per purchase.

**45. Ostomy Supplies.**

Benefits for ostomy supplies are limited to the following supplies:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

**46. Wigs.**

Wigs and other scalp hair prosthesis as a result of hair loss due to cancer treatment.

Benefits are limited to the first wig following cancer treatment not to exceed one Per Policy Year.

## **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
- Cystic fibrosis screening

**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), non-invasive fetal aneuploidy DNA testing

**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, except folic acid supplements with a written prescription. For additional information regarding Maternity Testing, please call the Company at 1-844-206-0374.

## **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 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:
- e.
  - 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.

- f. 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 or 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.

#### **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 care 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.

#### **Coordination of Benefits Provision**

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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.



## 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	\$10,000
Two or More Members	\$10,000
One Member	\$ 5,000
Thumb or Index Finger	\$ 2,500

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.

## Definitions

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**ADOPTED CHILD** means the adopted child placed with an Insured while that person is covered under this policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted child not more than 31 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured's residence.

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

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

**COMPLICATION OF PREGNANCY** means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

**CONGENITAL CONDITION** means a medical condition or physical anomaly arising from a defect existing at birth.

**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.

**CUSTODIAL CARE** means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**DAY HOSPITAL** means a facility that provides day rehabilitation services on an outpatient basis.

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

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

The Named Insured may cover an unmarried dependent child from age 26 until the Dependent's 28th birthday if the Dependent is all of the following:

1. The natural child, stepchild, or adopted child of the Named Insured.
2. A resident of this state or a full-time student at an accredited public or private institution of higher education.
3. Not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.
4. Not eligible for coverage under Medicaid or Medicare.

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

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

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

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

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

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

**EMERGENCY SERVICES** means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

**ESSENTIAL HEALTH BENEFITS** means the following general categories and the items and services covered within the categories:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

**HABILITATIVE SERVICES** means outpatient occupational therapy, physical therapy and speech therapy prescribed by the Insured Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

Habilitative services do not include services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Insured Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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

**HOSPITAL CONFINED/HOSPITAL CONFINEMENT** means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

**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, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which benefits are payable under this policy.

**INPATIENT REHABILITATION FACILITY** means a long term acute inpatient rehabilitation center, a Hospital (or special unit of a Hospital designated as an inpatient rehabilitation facility) that provides rehabilitation health services on an Inpatient basis as authorized by law.

**INSURED PERSON** means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term "Insured" also means Insured Person.

**INTENSIVE CARE** means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1. Progressive care.
2. Sub-acute intensive care.
3. Intermediate care units.
4. Private monitored rooms.
5. Observation units.
6. Other facilities which do not meet the standards for intensive care.

**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/MEDICALLY NECESSARY** means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

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

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

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

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

**MENTAL ILLNESS** means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

**NAMED INSURED** means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

**NEWBORN INFANT** means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

**OUT-OF-POCKET MAXIMUM** means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

**PHYSICIAN** means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

**PHYSIOTHERAPY** means short-term outpatient rehabilitation therapies (including Habilitative Services) administered by a Physician.

**POLICY YEAR** means the academic year beginning on the policy Effective Date and ending on the policy Termination Date.

**PRESCRIPTION DRUGS** mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

**REGISTERED NURSE** means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

**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.

**SKILLED NURSING FACILITY** means a Hospital or nursing facility that is licensed and operated as required by law.

**SOUND, NATURAL TEETH** means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

**SUBSTANCE USE DISORDER** means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

**URGENT CARE CENTER** means a facility that provides treatment required to prevent serious deterioration of the Insured Person's health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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

## Exclusions and Limitations

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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. Cosmetic procedures, except reconstructive procedures to:
  - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
  - Correct the following: 1) hemangiomas and port wine stains of the head and neck area for Insureds ages 18 and younger; 2) limb deformities such as club hand, club foot, syndactyly, polydactyly and macrodactyly; 3) Otoplasty when performed to improve hearing when ear or ears are absent or deformed; 4) tongue release for diagnosis of tongue-tied; 5) skull deformity caused by Congenital Conditions such as Crouzon's disease; 6) cleft lip; and 7) cleft palate.
  - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
2. 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.
3. Dental treatment, except:
  - For accidental Injury to Sound, Natural Teeth.
  - As described under Dental Treatment in the policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.

4. Elective Surgery or Elective Treatment.
5. Foot care for the following:
  - Routine foot care including the care, cutting and removal of corns, calluses, toenails.

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.

6. Health spa or similar facilities. Strengthening programs.
7. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:

- Hearing defects or hearing loss as a result of an infection or Injury.
- Benefits specifically provided in the policy.

8. Hypnosis.
9. 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.
10. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
11. Injury sustained while:
  - Participating in any intercollegiate, or professional sport, contest or competition.
  - Traveling to or from such sport, contest or competition as a participant.
  - Participating in any practice or conditioning program for such sport, contest or competition.
12. Investigational services.

13. Motor vehicle Injury.
14. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
15. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:
  - 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.
  - Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
  - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
  - Products used for cosmetic purposes.
  - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
  - Anorectics - drugs used for the purpose of weight control.
  - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
  - Growth hormones for children born small for gestational age.
  - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
16. Reproductive/Infertility services including but not limited to the following, except as specifically provided in the policy:
  - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
  - Reversal of sterilization procedures.
17. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.
18. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery.
 

This exclusion does not apply as follows:

  - When due to a covered Injury or disease process.
  - To benefits specifically provided in Pediatric Vision Services.
  - To the first pair of eyeglasses or contact lenses following intraocular lens implantation for the treatment of cataracts or aphakia or to replace the function of the human lens for conditions caused by cataract surgery or Injury.
  - To benefits specifically provided in the policy.
19. Preventive care services, except as specifically provided in the policy, including:
  - Routine physical examinations and routine testing.
  - Preventive testing or treatment.
  - Screening exams or testing in the absence of Injury or Sickness.
20. Services provided normally without charge by the Health Service of the Policyholder.
21. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
22. Supplies, except as specifically provided in the policy.
23. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
24. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

25. 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).
26. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat.

## **UnitedHealthcare Global: Global Emergency Services**

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If you are a member insured with this insurance plan, you and your insured spouse or Domestic Partner and minor child(ren) are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

International students, insured spouse or Domestic Partner and insured minor child(ren): you are eligible to receive UnitedHealthcare Global services worldwide, except in your home country.

Domestic students, insured spouse or Domestic Partner and insured minor child(ren): you are eligible for UnitedHealthcare Global 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.

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 UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

### **Key Services include:**

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to \$5,000.00 payment (when included with Your enrollment in a UnitedHealthcare **Student**Resources health insurance policy)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit [www.uhcsr.com/UHCGlobal](http://www.uhcsr.com/UHCGlobal) for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.



To access services please call:  
1-800-527-0218 Toll-free within the United States  
1-410-453-6330 Collect outside the United States

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

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

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

UnitedHealthcare Global 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 UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. Please refer to the UnitedHealthcare Global information in **My Account** at [www.uhcsr.com/MyAccount](http://www.uhcsr.com/MyAccount) for additional information, including limitations and exclusions.

## **NurseLine**

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Insureds have immediate access to nurse advice and a health information library 24 hours a day by calling the toll-free number listed on their medical ID card. NurseLine is staffed by both English and Spanish speaking Registered Nurses who can provide health information, support, and guidance on when to seek medical care. Translation services are available in more than 170 other languages for those insureds that need to speak with a nurse. More information about these services is available by logging into **My Account** at [www.uhcsr.com/MyAccount](http://www.uhcsr.com/MyAccount).

## **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 adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

**My Account** now includes 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.

## **Claim Procedures for Injury and Sickness Benefits**

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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, SR ID number (insured's insurance company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

HealthSmart Benefit Solutions, Inc.  
3320 West Market Street, Suite 100  
Fairlawn, OH 44333-3306  
1-844-206-0374

## **Pediatric Dental Services Benefits**

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Benefits are provided for Covered Dental Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) date the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

### **Section 1: Accessing Pediatric Dental Services**

#### **Network and Non-Network Benefits**

**Network Benefits** apply when the Insured Person chooses to obtain Covered Dental Services from a Network Dental Provider. Insured Persons generally are required to pay less to the Network Dental Provider than they would pay for services from a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will the Insured Person be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, the Insured must obtain all Covered Dental Services directly from or through a Network Dental Provider.

Insured Persons must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. Participation status can be verified by calling the Company and/or the provider. If necessary, the Company can provide assistance in referring the Insured Person to a Network Dental Provider.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 1-844-206-0374 to determine which providers participate in the Network.

**Non-Network Benefits** apply when Covered Dental Services are obtained from non-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. As a result, an Insured Person may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. In addition, when Covered Dental Services are obtained from non-Network Dental Providers, the Insured must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

#### **Covered Dental Services**

Benefits are eligible for Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service.

**Pre-Treatment Estimate**

If the charge for a Dental Service is expected to exceed \$300 or if a dental exam reveals the need for fixed bridgework, the Insured Person may receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the policy.

A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets the Insured Person know in advance approximately what portion of the expenses will be considered for payment.

**Pre-Authorization**

Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If the Insured Person does not obtain a pre-authorization, the Company has a right to deny the claim for failure to comply with this requirement.

If a treatment plan is not submitted, the Insured Person will be responsible for payment of any dental treatment not approved by the Company. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

**Section 2: Benefits for Pediatric Dental Services**

Benefits are provided for the Dental Services stated in this Section when such services are:

- A. Necessary.
- B. Provided by or under the direction of a Dental Provider.
- C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.
- D. Not excluded as described in Section 3: Pediatric Dental Services exclusions.

**Dental Services Deductible**

Benefits for pediatric Dental Services are not subject to the policy Deductible stated in the policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Policy Year is \$500 per Insured Person.

**Benefits**

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

<b>Benefit Description and Limitations</b>	<b>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
<b>Diagnostic Services</b>		
Intraoral Bitewing Radiographs (Bitewing X-ray)  Limited to 1 set of films every 6 months.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)  Limited to 1 film every 60 months.	50%	50%
Periodic Oral Evaluation (Checkup Exam)  Limited to 1 every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	50%	50%
<b>Preventive Services</b>		
Dental Prophylaxis (Cleanings)  Limited to 1 every 6 months.	50%	50%
Fluoride Treatments  Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50%	50%
Sealants (Protective Coating)  Limited to one sealant per tooth every 36 months.	50%	50%
<b>Space Maintainers</b>		
Space Maintainers  Limited to one per 60 months. Benefit includes all adjustments within 6 months of installation.	50%	50%
<b>Minor Restorative Services, Endodontics, Periodontics and Oral Surgery</b>		
Amalgam Restorations (Silver Fillings)  Multiple restorations on one surface will be treated as a single filling.	50%	50%
Composite Resin Restorations (Tooth Colored Fillings)  For anterior (front) teeth only.	50%	50%
Periodontal Surgery (Gum Surgery)  Limited to one quadrant or site per 36 months per surgical area.	50%	50%
Scaling and Root Planing (Deep Cleanings)  Limited to once per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance)  Limited to 4 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	50%	50%
Endodontics (root canal therapy) performed on anterior teeth, bicuspid, and molars  Limited to once per tooth per lifetime. Endodontic Surgery	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Simple Extractions (Simple tooth removal)  Limited to 1 time per tooth per lifetime.	50%	50%
Oral Surgery, including Surgical Extraction	50%	50%
<b>Adjunctive Services</b>		
General Services (including Emergency Treatment of dental pain)  Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary.	50%	50%
Occlusal guards for Insureds age 13 and older  Limited to one guard every 12 months.	50%	50%
<b>Major Restorative Services</b>		
Inlays/Onlays/Crowns (Partial to Full Crowns)  Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Fixed Prosthetics (Bridges)  Limited to once per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures)  Limited to one per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebasing Dentures  Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per 24 months.	50%	50%
<b>Implants</b>		
Implant Placement  Limited to once per 60 months.	50%	50%
Implant Supported Prosthetics  Limited to once per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis.  Limited to once per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report  Limited to once per 60 months.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium  Limited to once per 60 months.	50%	50%
Repair Implant Abutment by Support  Limited to once per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report  Limited to once per 60 months.	50%	50%
<b>MEDICALLY NECESSARY ORTHODONTICS</b>		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.		
Orthodontic Services  Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	50%	50%

### **Section 3: Pediatric Dental Exclusions**

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy.

Except as may be specifically provided under Section 2: Benefits for Covered Dental Services, benefits are not provided for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.

12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

#### **Section 4: Claims for Pediatric Dental Services**

When obtaining Dental Services from a non-Network provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

#### **Reimbursement for Dental Services**

The Insured Person is responsible for sending a request for reimbursement to the Company, on a form provided by or satisfactory to the Company.

#### **Claim Forms**

It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began.
- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage the Insured Person must include the name of the other carrier(s).

To file a claim, submit the above information to the Company at the following address:

HealthSmart Benefit Solutions, Inc.  
 3320 West Market Street, Suite 100  
 Fairlawn, OH 44333-3306  
 Claims Fax# 806-473-3136

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-844-206-0374.

### **Section 5: Defined Terms for Pediatric Dental Services**

The following definitions are in addition to the policy DEFINITIONS:

**Covered Dental Service** – a Dental Service or Dental Procedure for which benefits are provided under this section.

**Dental Emergency** - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

**Dental Provider** - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

**Dental Service or Dental Procedures** - dental care or treatment provided by a Dental Provider to the Insured Person while the policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

**Eligible Dental Expenses** - Eligible Dental Expenses for Covered Dental Services, incurred while the policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary Fees, as defined below.

**Necessary** - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Insured Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
- For treating a life threatening dental disease or condition.
- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined. The definition of Necessary used in this section relates only to benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.



**Usual and Customary Fee** - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary Fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that the Company accepts.

## **Pediatric Vision Care Services Benefits**

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Benefits are provided for Vision Care Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) date the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

### **Section 1: Benefits for Pediatric Vision Care Services**

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-844-206-0374. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com](http://www.myuhcvision.com).

When Vision Care Services are obtained from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then seek reimbursement from the Company as described under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, the Insured Person will be required to pay any Copayments at the time of service.

### **Network Benefits**

Benefits for Vision Care Services are determined based on the negotiated contract fee between the Company and the Vision Care Provider. The Company's negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

### **Non-Network Benefits**

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

### **Policy Deductible**

Benefits for pediatric Vision Care Services are not subject to any policy Deductible stated in the policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for Vision Care Services does not apply to the policy Deductible stated in the policy Schedule of Benefits.

### **Benefit Description**

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copayments and Coinsurance stated under each Vision Care Service in the Schedule of Benefits below.

## **Routine Vision Examination**

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well the Insured sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

**Eyeglass Lenses** - Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

The following Optional Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

**Eyeglass Frames** - A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

**Contact Lenses** - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

The Insured Person is eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Insured Person selects more than one of these Vision Care Services, the Company will pay Benefits for only one Vision Care Service.

**Necessary Contact Lenses** - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

## Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<b>Routine Vision Examination or Refraction only in lieu of a complete exam.</b>	Once per year.	100% after a Copayment of \$20.	50% of the billed charge.
<b>Eyeglass Lenses</b>	Once per year.		
• Single Vision		100% after a Copayment of \$40.	50% of the billed charge.
• Bifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Trifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Lenticular		100% after a Copayment of \$40.	50% of the billed charge.
<b>Eyeglass Frames</b>	Once per year		
• Eyeglass frames with a retail cost up to \$130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - \$160.		100% after a Copayment of \$15.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$160 - \$200.		100% after a Copayment of \$30.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - \$250.		100% after a Copayment of \$50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.		60%	50% of the billed charge.
<b>Contact Lenses</b>	Limited to a 12 month supply.		
• Covered Contact Lens Selection		100% after a Copayment of \$40.	50% of the billed charge.
• Necessary Contact Lenses		100% after a Copayment of \$40.	50% of the billed charge.

### Section 2: Pediatric Vision Exclusions

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy.

Except as may be specifically provided under Section 1: Benefits for Pediatric Vision Care Services, benefits are not provided for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in Section 1: Benefits for Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

### Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company.

## Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), the Insured Person must provide all of the following information at the address specified below:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:

HealthSmart Benefit Solutions, Inc.  
3320 West Market Street, Suite 100  
Fairlawn, OH 44333-3306  
1-844-206-0374  
Claims Fax #: 806-473-3136

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

## Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

**Covered Contact Lens Selection** - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

**Spectera Eyecare Networks** - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the policy.

**Vision Care Provider** - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

**Vision Care Service** - any service or item listed in Section 1: Benefits for Pediatric Vision Care Services.

## 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 1-844-206-0374 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: HealthSmart Benefit Solutions, Inc., 3320 West Market Street, Suite 100 Fairlawn, OH 44333-3306.

### **Expedited Internal Appeal**

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

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

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

To request an Expedited Internal Appeal, please contact Claims Appeals at 1-844-206-0374. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, HealthSmart Benefit Solutions, Inc., 3320 West Market Street, Suite 100 Fairlawn, OH 44333-3306.

### **Right to External Independent Review**

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

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

### **Standard External Review**

A Standard External Review request must be submitted in writing within 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 180 days 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  
HealthSmart Benefit Solutions, Inc.  
3320 West Market Street, Suite 100  
Fairlawn, OH 44333-3306  
1-844-206-0374

### **Questions Regarding Appeal Rights**

Contact Customer Service at 1-844-206-0374 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state department of insurance may be able to assist you at:

Office of Consumer Affairs  
Ohio Department of Insurance  
50 W. Town Street, Third Floor, Suite 300  
Columbus, OH 43215  
1-800-686-1526  
Website: [www.ohioinsurance.gov](http://www.ohioinsurance.gov)

### **Where to Find Help**

In case of an emergency, call 911 or go directly to the nearest emergency care facility.

For students experiencing a psychological crisis call Counseling and Consultation Service at (614) 292-5766.

For non-emergency situations call Student Health Services at (614) 292-4321 or Counseling and Consultation Service at (614) 292-5766.

For after hour's assistance, call the 24/7 NurseLine at 1-877-950-5004 PIN: 301

**For questions about:**

- Medical Benefits
- Claims Processing

**Please contact:**

Claims Administrator  
HealthSmart Benefit Solutions, Inc.  
3320 West Market Street, Suite 100  
Fairlawn, OH 44333-3306  
1-844-206-0374

**For questions about:**

- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

Please contact:

HealthSmart Rx, Inc.  
3320 West Market St.  
Fairlawn, OH 44333  
1-800-681-6912

**For questions about:**

Provider Listings

Please contact:

OSU Health Plan  
(614) 292-4700, or  
UnitedHealthcare Options PPO  
1-844-206-0374

A complete list of providers can be found at <http://osuhealthplan.com/network-access-search>. To find a UnitedHealthcare Options PPO provider outside of Franklin County, go to [www.uhcsr.com/osu](http://www.uhcsr.com/osu).

**Got Questions?**

As a UnitedHealthcare **StudentResources** Student Health insurance member, you have access to your school's secure member website, packed with personalized claims and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online. By logging into [www.uhcsr.com/MyAccount](http://www.uhcsr.com/MyAccount), you can:

- Review who is covered under your plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your plan.
- Send an e-mail to HealthSmart Student Health Customer Service at your convenience.
- View the latest health information and news, and more!

**How do I register?**

To create your account, visit [www.uhcsr.com/CreateAccount](http://www.uhcsr.com/CreateAccount). You can create your account with your first name, last name, date of birth and one of the following: school assigned email address, student ID number, or 7 digit SRID number listed on your UHCSR ID card.

The Ohio State University Student Health Insurance Plan is underwritten by UnitedHealthcare **StudentResources**.

## **IMPORTANT NOTE**

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to The Ohio State University. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. This student Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certificate of creditable coverage, please call the customer service number on your ID card.

The Plan is Underwritten by:

**UNITEDHEALTHCARE INSURANCE COMPANY**

### **Claims Status and all other Claim Inquires:**

Claims Administrator  
HealthSmart Benefit Solutions, Inc.  
3320 West Market Street, Suite 100  
Fairlawn, OH 44333-3306  
1-844-206-0374  
Email: akronclaims@healthsmart.com

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

This Brochure is based on Policy #2015-1098-1/4

**NOTE: Benefits and rates are subject to state and federal requirements. Company reserves the right to make any changes necessary to meet such requirements.**





**POLICY NUMBER: 2015-1098-1/4**

**NOTICE:**

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

**NOC# 7 (8/25/15)**

Preferred Provider Page:

Updated – UHC Behavior link to - United Behavioral Health Providers

**NOC# 6 (8/13/15)**

Medical Expense Benefits:

Physiotherapy – added Massage Therapy

**NOC#5 (8/11/15)**

Schedule of Benefits:

Sexual Reassignment Surgery – added hyperlink for guidelines

**NOC# 4 (8/6/15)**

Medical Expense Benefits:

Updated – Medical Emergency Expenses (Outpatient) to

Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies *and*:

- *X-rays.*
- *Laboratory procedures.*
- *Tests and procedures.*
- *Injections.*
- *Attending physician charges.*

All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.

**NOC# 3 (8/3/15)**

Schedule of Benefits:

Header:

Added- When treatment is rendered outside the United States, Covered Medical Expenses will be paid at the Preferred Provider (Tier 2) level of benefits.

Medical Emergency Benefit: updated to –

100% of Preferred Allowance up to the first \$500, then 90% thereafter

100% of Preferred Allowance up to the first \$500, then 90% thereafter

100% of Usual and Customary Charges up to the first \$500, then 90% thereafter

**NOC# 2 (7/29/15)**

Preferred Provider section:

added – UnitedHealthcare Options PPO United Behavioral Health (UBH) (Tier2) providers outside Franklin County.

added – UnitedHealthcare Options PPO United Behavioral Health (UHB):

<https://www.liveandworkwell.com/public>

**NOC# 1 (7/24/15)**

Student Health Services section:

Preventive Care Services:

added – and screening titers after Immunizations

added - Annual sexual health screening limited to one of each of the following tests based on age and patient history: Chlamydia, Gonorrhea, HIV, Syphilis

Allergy Testing, Treatment and Injections Services:

Removed – when administrated at Wilce Student Health Services ‘per availability’

Added – serum not included