



## 2016–2017 Student Injury and Sickness Insurance Plan



**I L L I N O I S**  
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

### Graduate Plan



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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 1-888-224-4883 or visiting us at [www.uhcsr.com/illinois](http://www.uhcsr.com/illinois).

## Introduction

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This booklet contains the principal provisions of the Policy which has been issued to your University. A copy of that Policy is available for your review at the University. In the event of an inadvertent conflict between the Policy and this booklet, the Policy will prevail. In the event of an inadvertent conflict between the Policy and Federal or State law, the law will prevail.

The University requires that all eligible students be covered by health insurance and provides a Plan for which the fee is automatically assessed along with other applicable tuition and fees. Coverage under the Plan is worldwide. Plan benefits are explained in the following pages. Plan 2, Policy number 2016-1351-2, is applicable to graduate students and their Dependents only.

The operation of McKinley Health Center is NOT part of the Student Health Insurance Plan, therefore, it is not necessary to be seen or referred by a Health Center Physician in order to receive the benefits of the Student Health Insurance Plan. Referral from the McKinley Health Center does not ensure benefits will be paid.

## Graduate Fee/Premium per Semester

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Student	\$409.00
Spouse of student*	\$395.00
One Child of student*	\$395.00
Two or More Children of student*	\$790.00
Spouse + Two or More Children of student*	\$1,186.00
*(student must also be insured)	

The Summer Session is considered a semester; a full semester fee/premium is required regardless of the effective date of insurance for the Student or Dependents.

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

## 2016-2017 Important Dates and Deadlines

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Deadlines are the dates by which exemptions, limited enrollment reinstatements or enrollment of Dependents must be accomplished. Students who late register will be given 14 calendar days from the date of registration, to complete exemptions and applications for Dependent coverage.

	Fall Semester	Spring Semester	Summer Session
Semester Coverage Periods:	08/21/2016 - 01/13/2017	01/14/2017 - 05/12/2017	05/13/2017 - 08/25/2017
Enrollment/ Change Period:	08/18/2016 - 09/09/2016	01/13/2017 - 02/03/2017	05/12/2017 - 06/02/2017

Dependents acquired through marriage, civil union or birth, including an adopted child, after the above deadline dates may be added for coverage provided application and proper premium is received within thirty-one (31) days after the date of marriage or birth (if the 31 day period encompasses a change in semester, premium will be required for both semesters in order for coverage to be retroactive to the date of the event).

Dependents of international students arriving in the United States after the semester deadline dates may be added for coverage provided application and proper premium is received within thirty-one (31) days of arrival in the United States.

## Eligibility

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Students of the University of Illinois who are taking credit hours are automatically enrolled in this Health Insurance Program at registration, unless proof of comparable coverage is furnished. Eligible students may also insure their Dependents. Eligible Dependents are the student's spouse, a party to a civil union established according to Illinois law, or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Brochure for the specific requirements needed to meet Domestic Partner eligibility.

**Graduate students** (as defined herein) of the University of Illinois who are enrolled, in attendance, and assessed all applicable fees are eligible for the Student Health Insurance Plan.

**Dependents** (as defined herein) of an Insured are also eligible provided application for coverage is made during Enrollment Periods detailed below.

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

Accident coverage for Intercollegiate Sports injuries is provided under a separate policy number, 2016-1351-8.

## Enrollment Periods and Effective Dates

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If Insured person, other than newborn, is an Inpatient in a healthcare facility on his/her Coverage Date, such person's Coverage Date will be the date of discharge.

Students assessed the insurance fee are automatically enrolled in this insurance Plan; the effective date will be the beginning "Semester Coverage Period" date for the appropriate semester as herein.

### **Purchase of Insurance for spouse, civil union partner, Domestic Partner and/or children:**

Dependent (spouse, civil union partner, domestic partner and/or children) coverage must be applied for each semester during the Enrollment/Change period listed in the Important Dates and Deadlines section. Coverage shall take effect on the date of application and receipt of proper premium by UnitedHealthcare **StudentResources**, or the appropriate semester beginning date, whichever is later. Dependents insured for the prior semester will have no lapse in coverage provided application and premium is received by the appropriate semester deadline date.

Dependent coverage is available for dependents of students who enroll in the Student Health Insurance Plan. Rates and enrollment information for dependents can be found on-line at [www.uhcsr.com/myaccount](http://www.uhcsr.com/myaccount).

If both parents are Insured students, changing child coverage from one parent to the other will not result in a lapse in coverage so long as the application and premium are received by that semester's deadline date. If an individual ceases to be an eligible student but is the Dependent of an Insured student, enrollment for Dependent coverage will not result in a lapse in coverage so long as the application and premium are received by that semester's deadline date.

If an Insured student acquires a Dependent, through marriage, birth or adoption after the listed semester deadline dates, the Dependent is eligible for coverage on the date the Dependent was acquired so long as application and premium payment is made within thirty-one (31) days after the date the Dependent was acquired (if the 31-day period encompasses a change in semesters, premium will be required for both semesters in order for coverage to be retroactive to the date of the event).

## Exemption

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Exemption from the insurance fee is granted when a student provides evidence of other health insurance coverage which has benefits equivalent to or better than the University Plan. The other coverage must be in effect on or before the first day of coverage of the University Plan. Acceptable evidence is a schedule of benefits and a certificate of coverage. International policies must be translated into English with monetary amounts presented in U.S. dollars.

To file for an Exemption students must complete the on-line Waiver request by going to [www.si.illinois.edu](http://www.si.illinois.edu), clicking on Opt Out and following the instructions. For date and deadline information, refer to the 2016-2017 Important Dates and Deadlines

section on page 1. Exemptions need be requested only once per policy year. Following approval of waiver, exemptions will be in effect for the current and subsequent semester(s) within the academic/policy year.

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## Reinstatement

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**Change of Status** Students exempt from the Student Injury and Sickness Insurance Plan who want to be reinstated to the Plan may apply by providing proof of loss of other insurance; i.e., notice of termination of insurance from the insurance company or employer, within sixty-three (63) days of such loss of other insurance by bringing in documentation to the Student Insurance Office in Urbana. Coverage is effective on the date of application or date of termination of other insurance whichever is later. Student must be registered and eligible to be assessed fee.

**Limited Enrollment** Students requesting reinstatement more than 63 days after the loss of other insurance, or if no loss of other coverage has occurred, must apply during the Enrollment/Change period of a semester they are eligible for coverage. Student must be registered and eligible to be assessed fee. Proof of loss should be taken to the Student Health Insurance office.

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## Continuation of Coverage

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### Graduating Students

Graduating students may elect to continue coverage for themselves and for Insured Dependents for up to the 90 day continuation period. Please refer to the continuation privilege section found on page 18 of this brochure for further details.

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

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## Extension of Coverage for Continuing Students

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Students who are not registered during a given semester may elect to extend their coverage during that semester, provided they were registered and enrolled in the coverage during the previous semester, and are returning the following semester.

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## Termination of Insurance

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The insurance of a student will terminate at 12:00 midnight (Central Standard Time) upon any of the following events, whichever shall first occur:

1. Failure to make premium payment.
2. Entry into the armed forces of any country. With respect to students, membership in the reserves with or without two consecutive full weeks of active training each year shall not be considered as entry into the armed forces.
3. Termination of membership in the class or classes eligible for insurance under this Plan:
  - With respect to students and Dependents, termination shall occur at the end of period for which premium has been paid. If premium for a specific semester is refunded, coverage for that semester is null and void.
  - With respect to Dependents, termination of membership shall occur upon ceasing to be a Dependent as defined.
  - With respect to Dependents reaching the limiting age, coverage will terminate on the first day of the next term.

Termination of a student's insurance shall immediately terminate the Dependents insurance. The discontinuance of the Plan shall immediately terminate all insurance hereunder. Such termination shall be without prejudice to any claim expense originating prior thereto. The discontinuance of any coverage provided hereunder shall immediately terminate the insurance of all Insured Persons with respect to the coverage discontinued except when the covered person is confined in the Hospital on the date coverage would otherwise terminate. In such cases, coverage will continue as described until date of discharge, but not more than ninety (90) days.

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## Extension of Benefits after Termination

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

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

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

## Schedule of Medical Expense Benefits

### METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 83.097 %

#### Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Outpatient Deductible	\$150 (Per Insured Person, Per Policy Year)
Coinsurance	80% except as noted below
Out-of-Pocket Maximum	\$1,800 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum	\$3,600 (For all Insureds in a Family, Per Policy Year)

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

UnitedHealthcare Options PPO Network of Hospitals and health care providers have agreed to accept special reimbursement rates for treatment rendered to Insureds; therefore, use of UnitedHealthcare Options PPO Network of Hospitals and health care providers may result in lower out of pocket expenses. All benefits payable for Covered Medical Expenses are subject to the Coinsurance noted above and the maximum benefits for each service specified below.

**Out-of-Pocket Maximum:** 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. 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. 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:

Inpatient	
<b>Room and Board Expense</b> After satisfying a \$100 per admission Deductible and paying the first \$5,000 at 80%, the balance of Room and Board charges and other hospital expenses incurred will be paid at 100%.	\$100 Deductible per Hospital Confinement
<b>Intensive Care</b>	Paid under Room & Board Expense
<b>Hospital Miscellaneous Expenses</b>	Paid under Room & Board Expense
<b>Routine Newborn Care</b>	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.	Usual and Customary Charges
<b>Assistant Surgeon Fees</b>	Usual and Customary Charges
<b>Anesthetist Services</b>	Usual and Customary Charges
<b>Registered Nurse's Services</b>	No Benefits
<b>Physician's Visits</b>	Usual and Customary Charges
<b>Pre-admission Testing</b> Pre-Admission testing must occur within 7 days prior to admission.	Paid under Hospital Miscellaneous Expenses

<b>Outpatient</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.	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.	Usual and Customary Charges
<b>Assistant Surgeon Fees</b>	Usual and Customary Charges
<b>Anesthetist Services</b>	Usual and Customary Charges
<b>Physician's Visits</b>	Usual and Customary Charges
<b>Physiotherapy</b> Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	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 Deductible is in addition to the Policy Deductible.	Usual and Customary Charges \$50 Deductible per visit
<b>Diagnostic X-ray Services</b>	Usual and Customary Charges
<b>Radiation Therapy</b>	Usual and Customary Charges
<b>Laboratory Procedures</b>	Usual and Customary Charges
<b>Tests &amp; Procedures</b>	Usual and Customary Charges
<b>Injections</b>	Usual and Customary Charges
<b>Chemotherapy</b>	Usual and Customary Charges
<b>Prescription Drugs</b>	UnitedHealthcare Pharmacy (UHCP) \$15 Copay per prescription for Tier 1 \$30 Copay per prescription for Tier 2 \$50 Copay per prescription for Tier 3 20% Coinsurance per prescription for Tier 4 up to a 31 day supply per prescription Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply. No benefits outside of UnitedHealthcare Network Pharmacy. Prescriptions filled utilizing McKinley Health Center are subject to a \$20 Copay per generic/\$35 Copay per brand name.

<b>Other</b>	
<b>Ambulance Services</b> Includes benefits for air ambulance.	Usual and Customary Charges
<b>Durable Medical Equipment</b>	Usual and Customary Charges
<b>Consultant Physician Fees</b>	Usual and Customary Charges
<b>Dental Treatment</b> Benefits paid on Injury to Sound, Natural Teeth only and surgical removal of complete bony impacted teeth.	Usual and Customary Charges
<b>Mental Illness Treatment</b>	Paid as any other Sickness
<b>Substance Use Disorder Treatment</b>	Paid as any other Sickness
<b>Maternity</b>	Paid as any other Sickness
<b>Elective Abortion</b>	Paid as any other Sickness
<b>Complications of Pregnancy</b>	Paid as any other Sickness
<b>Preventive Care Services</b> No Deductible or Coinsurance will be applied to Preventive Care Services. Please visit <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a> for a complete list of services provided for specific age and risk groups.	100% of Billed Charges

Other	
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness
Diabetes Services	Paid as any other Sickness
Home Health Care	Usual and Customary Charges
Hospice Care	Usual and Customary Charges
Inpatient Rehabilitation Facility	Usual and Customary Charges
Skilled Nursing Facility	Usual and Customary Charges
Urgent Care Center	Usual and Customary Charges
Hospital Outpatient Facility or Clinic	Usual and Customary Charges
Approved Clinical Trials	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness
Hearing Aids	Usual and Customary Charges \$500 Deductible per purchase
Medical Foods:	Usual and Customary Charges

## UnitedHealthcare Pharmacy Benefits

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

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

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

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

\$50 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

20% Coinsurance per prescription order or refill for a Tier 4 Prescription Drug up to a 31 day supply.

Mail order Prescription Drugs are available at 2.5 times the retail Copay up to a 90 day supply.

**Specialty Prescription Drugs** – if you require Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

**Designated Pharmacies** – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

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

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

### Additional Exclusions:

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.



2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven. This exclusion does not apply to drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration for that indication, if the drug has been prescribed for the Insured Person who has cancer, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia: (1) the American Hospital Formulary Service Drug Information; (2) National Comprehensive Cancer Network's Drugs & Biologics Compendium; (3) Thomson Micromedex's Drug Dex; (4) Elsevier Gold Standard's Clinical Pharmacology; (5) other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Service; or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-4.)
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided in the policy.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

**Definitions:**

**Brand-name** means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

**Chemically Equivalent** means when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy** means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

**Experimental or Investigational Services** means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

1. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.
3. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

1. Clinical trials for which benefits are specifically provided for in the policy.
2. If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

**Unproven Services** means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

1. Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
2. Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, consider an otherwise Unproven Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

**Generic** means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

**Network Pharmacy** means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

**New Prescription Drug Product** means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

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

**Prescription Drug Cost** means the rate the Company has agreed to pay the Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

**Prescription Drug List Management Committee** means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

**Specialty Prescription Drug Product** means Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products through the Internet at [www.uhcsr.com](http://www.uhcsr.com) or call Customer Service at 1-855-828-7716.

**Therapeutically Equivalent** means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

**Usual and Customary Fee** means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Fee includes a dispensing fee and any applicable sales tax.

**Insured Person's Right to Request an Exclusion Exception for UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits**

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-888-224-4883. The Company will notify the Insured Person of the Company's determination within 72 hours.

**Urgent Requests**

If the Insured Person's request requires immediate action and a delay could significantly increase the risk to the Insured Person's health, or the ability to regain maximum function, call the Company as soon as possible. The Company will provide a written or electronic determination within 24 hours.

**External Review**

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling the toll-free number on the Insured's ID card 1-888-224-4883. The *Independent Review Organization (IRO)* will notify the Insured Person of the determination within 72 hours.

**Expedited External Review**

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling the toll-free number on the Insured's ID card 1-888-224-4883 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

**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:

**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.
- 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 or Sickness.

**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.

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

**18. Diagnostic X-ray Services (Outpatient).**

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 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.

Benefits will be provided for prescribed orally administered cancer medications on a basis no less favorable than intravenously administered or injected cancer medications.

Benefits for prescription topical eye medication will be provided without regard to a coverage restriction for early refill of prescription renewals as long as:

- The medication is used to treat a chronic condition of the eye.
- The refill is requested by the Insured prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use.
- The prescribing Physician indicates on the original prescription that refills are permitted and that the early refills requested by the Insured do not exceed the total number of refills prescribed.

**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.

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.
- Surgical removal of bony impacted teeth.

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 endorsement attached.

Benefits will also be provided for anesthesia services and associated Hospital or ambulatory facility charges provided in conjunction with dental care for:

- An Insured child age 6 and under.
- An Insured who is disabled.
- An Insured with a medical condition requiring hospitalization or general anesthesia for dental care.

This benefit does not cover charges for the dental care itself, only charges for the anesthesia and associated Hospital or ambulatory facility charges.

**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.

**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.

**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*.

Required preventive care services are updated on an ongoing basis as guidelines and recommendations change. The complete and current list of preventive care services covered under the health reform law can be found at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits>. Current preventive care services are listed below.

Preventive care services for adults:

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use to prevent cardiovascular disease for men and women of certain ages.
- Blood pressure screening for all adults.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults over 50.
- Depression screening for adults.
- Diabetes (Type 2) screening for adults with high blood pressure.
- Diet counseling for adults at higher risk for chronic disease.
- Hepatitis B screening for people at high risk, including people from countries with 2 % or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.

- Hepatitis C screening for adults at increased risk, and one time for everyone born 1945 to 1965.
- HIV screening for everyone ages 15 to 65, and other ages at increased risk.
- Immunization vaccines for adults – doses, recommended ages and recommended populations vary.
- Lung cancer screening for adults 55 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.
- Obesity screening and counseling for all adults.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Syphilis screening for all adults at higher risk.
- Tobacco use screening for all adults and cessation interventions for tobacco users.

Preventive care services for women:

- Anemia screening on a routine basis for pregnant women.
- Breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer.
- Breast cancer mammography screenings every 1 to 2 years for women over 40.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women.
- Cervical cancer screening for sexually active women.
- Chlamydia infection screening for younger women and other women at higher risk.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a Physician for women with reproductive capacity (not including abortifacient drugs).
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- HIV screening and counseling for sexually active women.
- Human papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older.
- Osteoporosis screening for women over age 60 depending on risk factors.
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Sexually transmitted infections counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Urinary tract or other infection screening for pregnant women.
- Well-woman visits to get recommended services for women under 65.

Preventive care services for children:

- Alcohol and drug use assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Blood pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Cervical dysplasia screening for sexually active females.
- Depression screening for adolescents.
- Developmental screening for children under age 3.
- Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Fluoride chemoprevention supplements for children without fluoride in their water source.
- Gonorrhea prevention medication for the eyes of all newborns.
- Hearing screening for all newborns.
- Height, weight and body mass index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.



- Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2 % or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11 to 17 years of age.
- HIV screening for adolescents at higher risk.
- Hypothyroidism screening for newborns.
- Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary.
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Obesity screening and counseling.
- Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk, including bacterial infections, except infections that result from accident Injury, or infection resulting from accidental, involuntary or unintentional ingestion of a contaminated substance.
- Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Vision screening for all children.

**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 provided by a Registered Nurse or licensed practical nurse 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 teach 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 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private duty nursing does not include Custodial Care Service.

**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.

**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.

**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. Hearing Aids.**

Hearing aids when required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. If more than one type of hearing aid can meet the Insured's functional needs, benefits are available only for the hearing aid that meets the minimum specifications for the Insured's needs. Benefits are available to children up to age 19 and are limited to one hearing aid per hearing impaired ear every 36 months.

**45. Medical Foods.**

Benefits are limited to amino acid-based elemental formulas provided for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome. Medical foods must be prescribed by a Physician. The written prescription must accompany the claim when submitted.

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**Excess Provision**

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Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance.

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance.

However, this Excess Provision will not be applied to the first \$100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other group insurance does not cover the loss.

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**Accidental Death and Dismemberment Benefits**

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**Loss of Life, Limb or Sight**

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

**For Loss Of**

Life	\$ 5,000
Two or More Members	\$ 5,000
One Member	\$ 2,500

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.

## Continuation Privilege

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

## Definitions

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**ADOPTED CHILD** means the adopted child or foster child who is in the custody of the Insured, pursuant to an interim court order of adoption or placed with an Insured, regardless of whether the child resides with the 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 or foster 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.

Benefits will also be provided for another child placed in court-ordered temporary or other custody of the Insured from the moment of placement.

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.

**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, a party to a civil union, both same sex and different sex couples, established with all the obligations, protections, and legal rights that Illinois provides to married heterosexual couples, or Domestic Partner of the Named Insured and their dependent children. Dependent children include: an adopted child, a child who lives with the Insured from the time of the filing of a petition for adoption, a stepchild or recognized child who lives with the Insured in a parent-child relationship, or a child who lives with the Insured if such Insured is a court appointed guardian of the child. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

The Company may inquire of the Named Insured 2 months prior to attainment by a Dependent of the limiting age set forth in the policy, or at any reasonable time thereafter, whether such Dependent is in fact a disabled and dependent person and, in the absence of proof submitted within 60 days of such inquiry that such Dependent is a disabled and dependent person may terminate coverage of such person at or after attainment of the limiting age. In the absence of such inquiry, coverage of any disabled and dependent person shall continue through the term of such policy or any extension or renewal thereof.

**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.

**EXPERIMENTAL TREATMENT** means medical technology or a new application of existing medical technology, including medical procedures, drugs, and devices for treating a medical condition, illness, or diagnosis that: 1) is not generally accepted by informed health care professionals in the United States as effective; or 2) has not been proven by scientific testing or evidence to be effective.

**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.

**HABILITATIVE SERVICES** means health care services that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy and other services for people with disabilities.

Habilitative services do not include Elective Surgery or Elective Treatment or 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.

**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 or in facilities available

to the Hospital on a pre-arranged basis; and 6) is not primarily a clinic, nursing, rest or convalescent home. The requirement for major surgery facilities does not apply to treatment or services for rehabilitation or mental illness rendered in a hospital.

**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) the direct cause of loss, independent of disease cause of loss, independent of disease or bodily the direct cause of loss, independent of disease cause of loss, independent of disease or bodily infirmity
- 2) a source of loss.
- 3) treated by a Physician within 30 days after the date of accident.
- 4) 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. 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 sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

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

**MEDICAL NECESSITY/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 period of time 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, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acupuncture.
2. Learning disabilities.
3. Biofeedback.
4. 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.
  - Treat or correct Congenital Conditions
5. Dental treatment, except:
  - As described under Dental Treatment in the policy.This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
6. Elective Surgery or Elective Treatment.
7. Foot care for the following:
  - Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery).This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
8. Hearing examinations. Hearing aids, except as specifically provided for in the policy. 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.
  - Cochlear hearing aids.
  - A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
9. Hirsutism. Alopecia.
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 interscholastic, 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. Participation in a riot or civil disorder. Any loss to which a contributing cause was the Insured's commission of or attempt to commit a felony or to which a contributing cause was the Insured being engaged in an illegal occupation.
13. Prescription Drugs, services or supplies as follows:
  - 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.
  - Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use; except as specifically provided in Preventive Care Services.
  - Immunization agents, except as specifically provided in the policy. Biological sera.
  - 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, except when a Medical Necessity.
  - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
14. Reproductive/Infertility services including the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Female sterilization procedures, except as specifically provided in the policy.
    - Vasectomy.
    - Reversal of sterilization procedures.
  15. Routine eye examinations. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
  16. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
  17. 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.
  18. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except for treatment of temporomandibular joint dysfunction and craniomandibular disorders.
  19. Speech therapy, except as specifically provided in the policy.
  20. 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.
  21. Supplies, except as specifically provided in the policy.
  22. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
  23. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
  24. 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).
  25. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.

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

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If you are a member insured with this insurance plan, you and your insured spouse Domestic Partner or Civil Union 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 Domestic Partner or Civil Union Partner and insured minor child(ren): you are eligible to receive UnitedHealthcare Global services worldwide, except in your home country.

Domestic students, insured spouse Domestic Partner or Civil Union 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
- 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.

## **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. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

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## ID Cards

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

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## UHCSR Mobile App

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The UHCSR Mobile App is available for download from Google Play or Apple's App Store. Features of the Mobile App include easy access to:

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating Healthcare or Mental Health providers, call the office or facility; view a map.
- Find My Claims – view claims received within the past 60 days for both the primary insured and covered dependents; includes Provider, date of service, status, claim amount and amount paid.

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## UnitedHealth Allies

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

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## General Plan Provisions

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These provisions are extracts from the Policy and apply to all insurance provided hereunder.

**Proof of Loss:** Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

**Payment of Claims:** All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

**Right of Reimbursement:** If an Insured Person incurs expenses for Sickness or an Injury that occurred due to the negligence of a third party:

- a) The Company has the right to reimbursement for all benefits paid by the Company from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured Person, Insured Person's parents, if the Insured Person is a minor, or Insured Person's legal representative as a result of that Sickness or Injury.
- b) The Company is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Company for that Sickness or Injury

The Company has the right to reimbursement out of all funds the Insured Person, the Insured Person's parents, if the Insured Person is a minor, or the Insured Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

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

**Subrogation:** Whenever this policy has paid benefits because of Sickness or an Injury to any Insured Person resulting from a third party's wrongful act or negligence, to the extent of such payment the Company shall reserve the right to assume the legal claim any Insured Person may have against that third party. This means that the Company may choose to take legal action against the negligent third party or their representatives and to recover from them the amount of claim benefits paid to the Insured Person for loss caused by the third party.

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

In the event of Injury or Sickness, students should:

1. Report 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:

UnitedHealthcare **StudentResources**  
P.O. Box 809025  
Dallas, TX 75380-9025

## **Pediatric Dental Services Benefits**

Benefits are provided for Covered Dental Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) last day of the month 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 1-877-816-3596 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured's ID card.

**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 \$500 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.

## **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.

### **Out-of-Pocket Maximum**

Any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this benefit applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits.

### **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.

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.
<b>Diagnostic Services</b>		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	50%	50%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	50%	50%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 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 2 times per 12 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 once per first or second permanent molar every 36 months.	50%	50%
Space Maintainers (Spacers) 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%
Endodontics (Root Canal Therapy)	50%	50%
Periodontal Surgery (Gum Surgery) Limited to 1 quadrant or site per 36 months per surgical area.	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.	50%	50%
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 Dental Emergency treatment) 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. Occlusal guards limited to 1 guard every 12 months.	50%	50%
<b>Major Restorative Services</b> Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.		

<b>Benefit Description and Limitations</b>	<b>Network Benefits</b> Benefits are shown as a percentage of Eligible Dental Expenses.	<b>Non-Network Benefits</b> Benefits are shown as a percentage of Eligible Dental Expenses.
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 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 1 time per 12 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 1 per 6 months.	50%	50%
<b>Implants</b>		
Implant Placement Limited to 1 time per 60 months.	50%	50%
Implant Supported Prosthetics Limited to 1 time per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	50%	50%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	50%	50%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report Limited to 1 time 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**

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. Benefits may be Covered Medical Expenses available under the policy. Refer to the policy Medical Expense Benefits.
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. Benefits may be Covered Medical Expenses available under the policy. Refer to the policy Medical Expense Benefits.
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. Benefits may be Covered Medical Expenses available under the policy. Refer to the policy Medical Expense Benefits.
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. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the policy.

### **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:

UnitedHealthcare Dental  
Attn: Claims Unit  
P.O. Box 30567  
Salt Lake City, UT 84130-0567

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 1-877-816-3596. This number is also listed on the Insured's Dental ID Card.

## **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 endorsement.

**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.

**Experimental, Investigational, or Unproven Service** - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

**Foreign Services** - services provided outside the U.S. and U.S. Territories

**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 in this endorsement. The definition of Necessary used in this endorsement relates only to benefits under this endorsement 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) last day of the month 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 1-800-839-3242. 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.

**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.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

**Low Vision** – Benefits are available to an Insured Person who has severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by the Company.

This benefit includes:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

**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>Lens Extras</b>	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% 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.
<b>Low Vision Services</b> Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Services, the Insured will be required to pay all billed charges at the time of service. The Insured may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
• Low Vision Testing		100% of the billed charge.	75% of the billed charge.
• Low Vision Therapy		100% of the billed charge.	75% of the billed charge.

## Section 2: Pediatric Vision Exclusions

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:

Claims Department  
P.O. Box 30978  
Salt Lake City, UT 84130

By facsimile (fax):

1-248-733-6060

#### **Reimbursement for Low Vision Services**

To file a claim for reimbursement for Low Vision Services, 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:

Claims Department  
P.O. Box 30978  
Salt Lake City, UT 84130

By facsimile (fax):

1-248-733-6060

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 1-888-224-4883 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **StudentResources**, PO Box 809025, Dallas, TX 75380-9025.

#### **Expedited Internal Appeal**

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

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

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

To request an Expedited Internal Appeal, please contact Claims Appeals at 1-888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **StudentResources**, PO Box 809025, Dallas, TX 75380-9025.

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

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

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

#### **Standard External Review**

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

#### **Expedited External Review**

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

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

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

or

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

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

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

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

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

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

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

or

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

### **Where to Send External Review Requests**

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

Illinois Department of Insurance  
Office of Consumer Health Insurance  
External Review Request  
320 W. Washington Street  
Springfield, IL 62767  
1-877-850-4740 toll free phone  
1-217-557-8495 fax



### **Questions Regarding Appeal Rights**

Contact Customer Service 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:

Illinois Department of Insurance  
Office of Consumer Health Insurance  
External Review Request  
320 W. Washington Street  
Springfield, IL 62767  
1-877-850-4740 toll free phone  
1-217-557-8495 fax  
[Insurance.Illinois.gov/ExternalReview](http://Insurance.Illinois.gov/ExternalReview)

The Plan is Underwritten by:  
**UNITEDHEALTHCARE INSURANCE COMPANY**

Administrative Office:  
UnitedHealthcare **StudentResources**  
P.O. Box 809025  
Dallas, Texas 75380-9025  
1-888-224-4883  
1-972-233-8200

General Inquiries:  
Student Health Insurance Office  
McKinley Health Center  
1109 S. Lincoln Avenue  
Room 29  
Urbana, IL 61801  
1-217-333-0165  
Email: [insure@illinois.edu](mailto:insure@illinois.edu)  
Web: [si.illinois.edu](http://si.illinois.edu)

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 #2016-1351-2.

