



## 2016–2017 Student Injury and Sickness Insurance Plan

Designed Especially for the Domestic Students of



**Georgia Gwinnett**  
COLLEGE



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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 1-866-403-8267 or visiting us at [www.uhcsr.com/usg](http://www.uhcsr.com/usg).

## **Eligibility**

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All DOMESTIC students enrolled in six (6) or more credits per term, or participating in Cooperative Education Programs and are enrolled in a degree-seeking program; OR all DOMESTIC Graduate and Professional students enrolled in a minimum of three (3) graduate level credit hours and enrolled in a degree-seeking program are eligible to enroll in this insurance Plan, excluding those students that are required to enroll in this insurance Plan as stated below.

The following students required to enroll in this insurance Plan are as follows:

1. All DOMESTIC undergraduate students enrolled in programs that require proof of health insurance.
2. All DOMESTIC graduate students receiving a Full Tuition Waiver as part of their graduate assistantship award.
3. All DOMESTIC graduate students enrolled in programs that require proof of health insurance.
4. All DOMESTIC graduate students receiving fellowships that fully fund their tuition.

Accident coverage for Intercollegiate Sports injuries is available under a separate policy number 2016-202728-8. Contact the school for information on the Intercollegiate Sports Plan.

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

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

Dependent Eligibility expires concurrently with that of the Insured student.

## **Effective and Termination Dates**

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The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2016. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., July 31, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

## **Extension of Benefits after Termination**

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

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

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

## **Pre-Admission Notification**

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

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

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

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

## **Preferred Provider Information**

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

UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-866-403-8267 and/or by asking the provider when making an appointment for services.

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

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

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

### **Inpatient Expenses**

**PREFERRED PROVIDERS** - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-866-403-8267 for information about Preferred Hospitals.

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

### **Outpatient Hospital Expenses**

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

### **Professional & Other Expenses**

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

## Schedule of Medical Expense Benefits

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METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 80.918%

### Injury and Sickness Benefits

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

|   |  |
|---|--|
| Deductible Preferred Providers            | \$500 (Per Insured Person, Per Policy Year)              |
| Deductible Preferred Providers            | \$1,250 (For all Insureds in a Family, Per Policy Year)  |
| Deductible Out-of-Network                 | \$800 (Per Insured Person, Per Policy Year)              |
| Deductible Out-of-Network                 | \$1,450 (For all Insureds in a Family, Per Policy Year)  |
| Coinsurance Preferred Providers           | 80% except as noted below                                |
| Coinsurance Out-of-Network                | 60% except as noted below                                |
| Out-of-Pocket Maximum Preferred Providers | \$6,350 (Per Insured Person, Per Policy Year)            |
| Out-of-Pocket Maximum Preferred Providers | \$12,700 (For all Insureds in a Family, Per Policy Year) |
| Out-of-Pocket Maximum Out-of-Network      | \$10,500 (Per Insured Person, Per Policy Year)           |
| Out-of-Pocket Maximum Out-of-Network      | \$33,500 (For all Insureds in a Family, Per Policy Year) |

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

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

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

**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. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. 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. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network per service Deductibles.

**Student Health Center Benefits:** The Deductible will be waived for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

UnitedHealthcare Pharmacy (UHCP) is the vendor the company contracts with to provide a network of pharmacies.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. 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   | Preferred Provider         | Out-of-Network Provider     |
|---|----------------------------|-----------------------------|
| <b>Room and Board Expense</b>   | Preferred Allowance        | Usual and Customary Charges |
| <b>Intensive Care</b>   | Preferred Allowance        | Usual and Customary Charges |
| <b>Hospital Miscellaneous Expenses</b>  | Preferred Allowance        | Usual and Customary Charges |
| <b>Routine Newborn Care</b><br>See Benefits for Postpartum Care   | Paid as any other Sickness | Paid as any other Sickness  |
| <b>Surgery</b><br>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. | Preferred Allowance        | Usual and Customary Charges |
| <b>Assistant Surgeon Fees</b>   | Preferred Allowance        | Usual and Customary Charges |
| <b>Anesthetist Services</b>   | Preferred Allowance        | Usual and Customary Charges |
| <b>Nurse's Services</b>   | Preferred Allowance        | Usual and Customary Charges |
| <b>Physician's Visits</b>   | Preferred Allowance        | Usual and Customary Charges |
| <b>Pre-admission Testing</b><br>Payable within 7 working days prior to admission.   | Preferred Allowance        | Usual and Customary Charges |

| Outpatient  | Preferred Provider                                  | Out-of-Network Provider            |
|---|---|------------------------------------|
| <b>Surgery</b><br>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. | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Day Surgery Miscellaneous</b><br>Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.   | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Assistant Surgeon Fees</b>   | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Anesthetist Services</b>   | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Physician's Visits</b>   | 100% of Preferred Allowance<br>\$20 Copay per visit | 70% of Usual and Customary Charges |
| <b>Physiotherapy</b><br>Limits Per Policy Year as follows:<br>30 visits for any combination of physical therapy and occupational therapy<br>30 visits of speech therapy<br>30 visits of manipulative therapy  | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Medical Emergency Expenses</b><br>Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.   | Preferred Allowance                                 | 80% of Usual and Customary Charges |
| <b>Diagnostic X-ray Services</b>  | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Radiation Therapy</b>  | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Laboratory Procedures</b>  | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Tests &amp; Procedures</b>   | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Injections</b>   | Preferred Allowance                                 | Usual and Customary Charges        |
| <b>Chemotherapy</b>   | Preferred Allowance                                 | Usual and Customary Charges        |

| <b>Outpatient</b>         | <b>Preferred Provider</b>   | <b>Out-of-Network Provider</b>  |
|---------------------------|---|---|
| <b>Prescription Drugs</b> | UnitedHealthcare Pharmacy (UHCP)<br>\$25 Copay per prescription for Tier 1<br>\$50 Copay per prescription for Tier 2<br>\$75 Copay per prescription for Tier 3<br>up to a 31-day supply per prescription<br>Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.<br>University Health Center Pharmacy:<br>Copay waived for generic drugs / \$5 Copay per prescription for brand name drugs, \$10 Copay per prescription for non-formulary drugs / up to a 31 day supply per prescription if prescription is filled at the University Health Center Pharmacy. | \$25 Deductible per prescription for generic drugs<br>\$50 Deductible per prescription for brand name drugs<br>up to a 31 day supply per prescription |

| <b>Other</b>   | <b>Preferred Provider</b>  | <b>Out-of-Network Provider</b>      |
|--|--|-------------------------------------|
| <b>Ambulance Services</b>  | 70% of Preferred Allowance<br>If ambulance referral is initiated by Student Health Center, Deductible is waived. | 70% of Usual and Customary Charges  |
| <b>Durable Medical Equipment</b>   | Preferred Allowance  | Usual and Customary Charges         |
| <b>Consultant Physician Fees</b>   | Preferred Allowance  | Usual and Customary Charges         |
| <b>Dental Treatment</b><br>Benefits paid on Injury to Sound, Natural Teeth or as specifically provided in the policy only.   | Preferred Allowance  | 80% of Usual and Customary Charges  |
| <b>Mental Illness Treatment</b>  | Paid as any other Sickness   | Paid as any other Sickness          |
| <b>Substance Use Disorder Treatment</b>  | Paid as any other Sickness   | Paid as any other Sickness          |
| <b>Maternity</b><br>See also Benefits for Postpartum Care  | Paid as any other Sickness   | Paid as any other Sickness          |
| <b>Complications of Pregnancy</b>  | Paid as any other Sickness   | Paid as any other Sickness          |
| <b>Elective Abortion</b>   | No Benefits  | No Benefits                         |
| <b>Preventive Care Services</b><br>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.<br><br>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 Preferred Allowance  | 100% of Usual and Customary Charges |
| <b>Reconstructive Breast Surgery Following Mastectomy</b><br>See Benefits for Mastectomy   | Paid as any other Sickness   | Paid as any other Sickness          |
| <b>Diabetes Services</b><br>See Benefits for the Management and Treatment of Diabetes  | Paid as any other Sickness   | Paid as any other Sickness          |
| <b>Home Health Care</b>  | Preferred Allowance  | Usual and Customary Charges         |
| <b>Hospice Care</b>  | Preferred Allowance  | Usual and Customary Charges         |
| <b>Inpatient Rehabilitation Facility</b>   | Preferred Allowance  | Usual and Customary Charges         |
| <b>Skilled Nursing Facility</b>  | Preferred Allowance  | Usual and Customary Charges         |
| <b>Urgent Care Center</b>  | Preferred Allowance  | Usual and Customary Charges         |

| Other  | Preferred Provider         | Out-of-Network Provider     |
|--|----------------------------|-----------------------------|
| <b>Hospital Outpatient Facility or Clinic</b>  | Preferred Allowance        | Usual and Customary Charges |
| <b>Approved Clinical Trials</b><br>See also Benefits for Drugs for Treatment of Children's Cancer  | Paid as any other Sickness | Paid as any other Sickness  |
| <b>Transplantation Services</b>  | Paid as any other Sickness | Paid as any other Sickness  |
| <b>Breast Reduction Surgery</b>  | Paid as any other Sickness | Paid as any other Sickness  |
| <b>Child Wellness Services</b><br>No Deductible will be applied when the services are for a child age 5 and under.   | Paid as any other Sickness | Paid as any other Sickness  |
| <b>Needle Stick/Blood &amp; Body Fluid and Infectious Disease Exposure</b><br>Benefits are limited to Insured students for an exposure to blood/body fluid/infectious disease during a clinical rotation by any route. | Preferred Allowance        | Usual and Customary Charges |

### **UnitedHealthcare Network Pharmacy and Out-of-Network 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/usg](http://www.uhcsr.com/usg) or call 1-855-828-7716 for the most up-to-date tier status.

\$25 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

\$50 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

\$75 Copay per prescription order or refill for a Tier 3 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 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/usg](http://www.uhcsr.com/usg) and log in to your online account or call 1-855-828-7716.

Benefits are available for Prescription Drugs at an Out-of-Network Pharmacy as specified in the Schedule of Benefits subject to all terms of the policy.

When prescriptions are filled at pharmacies outside the network, the Insured must pay for the prescriptions out-of-pocket and submit the receipts for reimbursement to UnitedHealthcare **StudentResources**, P.O. Box 809025, Dallas, TX 75380-9025. See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.



### **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, except for cancer drugs found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in either 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-3.)
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.
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:**

**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.

**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.

**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.

**Out-of-Network Pharmacy** means a pharmacy that has not been designated by the Company as 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/usg](http://www.uhcsr.com/usg) or call Customer Service at 1-855-828-7716.

**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/usg](http://www.uhcsr.com/usg) or call Customer Service at 1-855-828-7716.

### **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 1-866-403-8267. 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 1-866-403-8267. 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 1-866-403-8267 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. See Benefits for Postpartum Care.

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. **Nurse's Services.**

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, trauma, stroke, surgery, cancer, or vocal nodules.
17. **Medical Emergency Expenses (Outpatient).**  
Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies.
- All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. **Diagnostic X-ray Services (Outpatient).**  
Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
19. **Radiation Therapy (Outpatient).**  
See Schedule of Benefits.
20. **Laboratory Procedures (Outpatient).**  
Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
21. **Tests and Procedures (Outpatient).**  
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
- Physician's Visits.
  - Physiotherapy.
  - X-rays.
  - Laboratory Procedures.
- The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
  - Infusion therapy.
  - Pulmonary therapy.
  - Respiratory therapy.
- Tests and Procedures for preventive care are provided as specified under Preventive Care Services.
22. **Injections (Outpatient).**  
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy (Outpatient).**

See Schedule of Benefits.

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

See Schedule of Benefits. Benefits will not be denied for prescription inhalants required to enable an Insured Person to breathe when suffering from asthma or other life-threatening bronchial ailments based upon any restriction on the number of days before an inhaler refill may be obtained if ordered or prescribed by a Physician.

**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.

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.
- Removal of impacted wisdom teeth.
- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that would lead to functional impairments.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

Benefits will also be paid the same as any other Injury or Sickness for facility and general anesthesia charges for dental care provided to:

- An Insured who is age 7 or younger or who is developmentally disabled.
- An Insured for whom a successful result cannot be expected by local anesthesia due to a neurological disorder.
- An Insured who has sustained extensive facial or dental trauma.

Pediatric dental benefits are provided in the Pediatric Dental Services provision.

29. **Mental Illness Treatment.**

Benefits will be paid for services received:

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

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.
- Services may be received in a Hospital licensed in Georgia that specializes in the treatment of alcoholics or drug addicts and that is operated primarily for the treatment of such persons.
31. **Maternity.**  
Same as any other Sickness. See also Benefits for Postpartum Care.
32. **Complications of Pregnancy.**  
Same as any other Sickness.
33. **Preventive Care Services.**  
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
  - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
  - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
  - With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
34. **Reconstructive Breast Surgery Following Mastectomy.**  
Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Mastectomy.
35. **Diabetes Services.**  
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for the Management and Treatment of Diabetes.
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.
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.

See also Benefits for Drug Treatment of Children's Cancer.

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. **Breast Reduction Surgery.**

When Medically Necessary and when the following criteria are met:

- The Company determines that the surgery is performed to treat a physiologic functional impairment.
- The surgery is not determined to be for cosmetic purposes only.

45. **Child Wellness Services.**

Preventive services for Insured Dependents age 5 and under.

Benefits are limited to:

- Age appropriate immunizations.
- Development assessment of the Dependent.
- Laboratory testing.
- Periodic health assessments.

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## **Mandated Benefits**

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### **BENEFITS FOR MAMMOGRAPHY**

Benefits will be paid the same as any other Sickness for a mammogram subject to all of the terms and conditions of the policy and according to the following guidelines:

1. Once as a baseline mammogram for any female who is at least 35 but less than 40 years of age;
2. Once every two years for any female who is at least 40 but less than 50 years of age;
3. Once every year for any female who is at least 50 years of age; and
4. When ordered by a Physician for a female at risk.

For purpose of this benefit, "Female at risk" means a woman:

1. Who has a personal history of breast cancer;
2. Who has a personal history of biopsy proven benign breast disease;
3. Whose grandmother, mother, sister, or daughter has had breast cancer; or
4. Who has not given birth prior to the age of 30.

Reimbursement will be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by the state of Georgia.

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

### **BENEFITS FOR PAP SMEARS**

Benefits will be paid the same as any other Sickness for an annual "Pap smear" or "Papanicolaou smear" examination for the purpose of detecting cancer, or more frequently if ordered by a Physician. The examination must be performed in accordance with standards established by the American College of Pathologists.

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

### **BENEFITS FOR PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS**

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) test to detect the presence of prostate cancer. The test will be covered on an annual basis for an Insured males who is 45 years of age or older. The test will also be covered for an Insured male 40 years of age or older, when ordered by a Physician. All tests must be performed in accordance with standards established by the American College of Pathologists.

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



### **BENEFITS FOR CHLAMYDIA SCREENING**

Benefits will be paid the same as any other Sickness for one annual chlamydia screening test for each Insured Person. "Chlamydia screening test" means any laboratory test of the urogenital tract which specifically detects for infection by one or more agents of chlamydia trachomatis and which test is approved for such purposes by the federal Food and Drug Administration.

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

### **BENEFITS FOR MASTECTOMY**

Benefits will be paid the same as any other Sickness for a mastectomy including breast reconstructive surgery of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedemas, and at least two external postoperative prostheses incidental to the covered mastectomy. Coverage will be provided in a manner determined in consultation with the attending Physician.

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

### **BENEFITS FOR BONE MASS MEASUREMENT**

Benefits will be paid the same as any other Sickness for Qualified Insured Persons for scientifically proven Bone Mass Measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis.

1. "Bone mass measurement" means a radiologic or radioisotopic procedure or other technologies approved by the United States Food and Drug Administration and performed on an individual for the purpose of identifying bone mass or detecting bone loss.
2. "Qualified Insured Person" means an:
  - a. Estrogen-deficient woman or individual at clinical risk of osteoporosis as determined directly or indirectly by a physician and who is considering treatment;
  - b. Individual with osteoporotic vertebral abnormalities;
  - c. Individual receiving long-term glucocorticoid (steroid) therapy;
  - d. Individual with primary hyperparathyroidism; or
  - e. Individual being monitored directly or indirectly by a physician to assess the response to or efficacy of approved osteoporosis drug therapies.

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

### **BENEFITS FOR COLORECTAL CANCER SCREENING**

Benefits will be paid the same as any other Sickness for colorectal cancer screening, examinations and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, for the ages, family histories, and frequencies referenced in such guidelines and recommendations and deemed appropriate by the attending physician after conferring with the patient.

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

### **BENEFITS FOR DENTAL ANESTHESIA**

Benefits will be provided for general anesthesia and associated hospital and ambulatory surgical facility charges in conjunction with dental care provided to an Insured, if such person is:

1. Seven years of age or younger or is developmentally disabled;
2. An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Insured; or
3. An individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.

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

## BENEFITS FOR THE MANAGEMENT AND TREATMENT OF DIABETES

Benefits will be provided for all Covered Medical Expenses related to the medically appropriate and necessary medical equipment, supplies, pharmacologic agents, and outpatient self-management training and education, including medical nutrition therapy, for an Insured Person with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes who adhere to the prognosis and treatment regimen prescribed by a Physician.

“Pharmacologic agents” include:

1. Insulin of each class approved by the federal Food and Drug Administration (FDA) including formulations available either in a vial or cartridge;
2. Prescription insulin of each class approved by the FDA including formulations available either in a vial or cartridge formulation;
3. Prescription oral medications of each class approved by the FDA for the management of diabetes;
4. Oral products approved by the FDA for the management of diabetes;
5. Glucagon kits; and Pharmacologic agents approved by the FDA for the management of diabetes and its complications.

“Medical equipment” includes the following medical equipment, non-disposable and durable medical equipment when prescribed by a Physician:

1. Blood glucose monitors and glucose monitors, including commercially available blood glucose monitors;
2. Blood glucose monitors and glucose monitors for the legally blind or visually impaired due to diabetes, including commercially available blood glucose monitors with adaptive devices for the blind;
3. Injection aids, including those adaptable to meet the needs of the legally blind, to assist with insulin injection;
4. Insulin pumps, which includes insulin infusion pumps;
5. Medical supplies for use with or without insulin pumps and insulin infusion pumps, including durable devices to assist with the injection of insulin and infusion sets;
6. Therapeutic shoes, custom fitted inserts and related orthopedic footwear associated with the prevention and treatment of diabetes and diabetes related complications;
7. Pen-like insulin injection devices designed for multiple use;
8. Lancing devices associated with the drawing for blood samples for use with blood glucose monitors; and
9. Other medical equipment, non-disposable and durable medical equipment that is Medically Necessary and consistent with the current standards of care of the American Diabetes Association.

“Supplies” means the following single-use medical supplies when prescribed by a Physician:

1. Test strips for glucose monitors, which include test strips whose performance achieved clearance by the FDA;
2. Visual reading and urine testing strips, which includes visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones;
3. Lancets and single use lancing devices used in conjunction with the monitoring of glycemic control;
4. Syringes, which includes insulin syringes, insulin injection needles for use with pen-like insulin injection devices and other disposable parts required for insulin injection aids;
5. Medical supplies for use with insulin pumps and insulin infusion pumps to include disposable devices to assist with the injection of insulin and infusion sets, alcohol swabs and related preparations and other similar compounds associated with the cleansing of injection sites prior to the administration of insulin; and
6. Such other single-use medical supplies that are Medically Necessary and consistent with the current standards of care of the American Diabetes Association.

Diabetes self-management training and medical nutrition therapy services must be prescribed by a Physician. The diabetes self-management training program must be:

1. Provided under a training program that is recognized by the federal Centers for Medicare & Medicaid services (CMS); or
2. Approved, accredited or certified by a national organization assessing standards of quality in the provision of diabetes self-management education.

Diabetes self-management training programs shall be provided when the following criteria are met:

1. Upon a Physician's diagnosis that the Insured Person has diabetes;
2. Upon a significant change in an Insured Person's diabetes related condition;

3. Upon a change in an Insured Person's diagnostic levels;
4. Upon a change in treatment regimen;
5. Upon an Insured Person's initiation of insulin therapy;
6. Upon identification of inadequate diabetes control as evidenced by diagnostic laboratory tests falling outside of acceptable ranges;
7. Upon determination that an Insured Person is at high risk for complications based on inadequate glycemic control documented by acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the Insured Person's history during which the insured Person needed emergency room visits or hospitalization;
8. Upon determination that an Insured Person is at high risk based on at least one of the documented diabetes related complications, including:
  - a. Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation;
  - b. Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye;
  - c. Kidney complications related to diabetes, when manifested by albuminuria without other cause, or elevated creatinine.

Medical nutrition therapy services shall be provided in addition to diabetes self-management training when the following are met:

1. Upon a Physician's diagnosis that an Insured Person has diabetes;
2. Upon a significant change in an Insured Person's diabetes related condition;
3. Upon a change in an Insured Person's diagnostic levels;
4. Upon a change in treatment regimen;
5. Upon an Insured Person's initiation of insulin therapy;
6. Upon identification of inadequate diabetes control as evidenced by diagnostic laboratory tests falling outside of acceptable ranges;
7. Upon determination that an Insured Person is at high risk for complications based on inadequate glycemic control documented by acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the Insured Person's history during which the insured Person needed emergency room visits or hospitalization;
8. Upon determination that an Insured Person is at high risk based on at least one of the documented diabetes related complications, including:
  - a. Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation;
  - b. Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye;
  - c. Kidney complications related to diabetes, when manifested by albuminuria without other cause, or elevated creatinine.

Instructions in diabetes self-management training shall be provided by a healthcare professional who is either: (1) a certified diabetes educator; and/or (2) a certified, registered or licensed health professional with expertise in diabetes satisfying criteria for Medicare coverage for diabetes education and training pursuant to 42 CFR Part 410. Instruction in medical nutrition therapy shall be provided by a healthcare professional who is either: (1) a registered dietitian; and/or (2) a certified, registered, or licensed health professional with expertise in medical nutrition therapy satisfying criteria for Medicare coverage for medical nutrition therapy pursuant to 42 CFR Part 410.

Primary or initial diabetes self-management training and medical nutrition therapy services shall be provided in group settings for a total of 10 hours in the initial year after diagnosis unless the following criteria are met: (1) a group session is not available within two months of the date diabetes self-management training or medical nutrition therapy are ordered; or (2) the Insured Person's Physician documents that the Insured Person has special needs that will hinder effective participation in a group training session. Secondary or follow-up diabetes self-management training and medical nutrition therapy shall be provided during individual patient meetings or sessions within the first twelve months after a primary or initial diabetes self-management training or medical nutrition therapy group session.

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

#### **BENEFITS FOR SURVEILLANCE TESTS FOR OVARIAN CANCER**

Benefits will be paid the same as any other Sickness for surveillance tests for ovarian cancer for an Insured Person age 35 and older at risk for ovarian cancer.

At risk for ovarian cancer means having a family history: with one or more first or second degree relatives with ovarian cancer; of clusters of women relatives with breast cancer; of nonpolyposis colorectal cancer; or testing positive for BRCA1 or BRCA2 mutations.

Surveillance tests means annual screening using: CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.

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

#### **BENEFITS FOR TELEMEDICINE**

Benefits will be paid the same as any other Sickness for Telemedicine as for services received on a face-to-face basis. "Telemedicine" means the practice, by a duly licensed Physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof do not constitute telemedicine services.

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

#### **BENEFITS FOR DRUG TREATMENT OF CHILDREN'S CANCER**

Benefits will be paid the same as any other Sickness for routine patient care costs incurred in connection with the provision of goods or services to Dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those children who are enrolled in an approved clinical trial program for treatment of children's cancer and are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors or other similar sources.

"Approved clinical trial program for treatment of children's cancer" means a Phase II and III prescription drug clinical trial program in this state, as approved by the federal Food and Drug Administration or the National Cancer Institute for the treatment of cancer that generally first manifests itself in children under the age of 19. Such program must: (i) test new therapies, regimens, or combinations thereof against standard therapies or regimens for the treatment of cancer in children; (ii) introduce a new therapy or regimen to treat recurrent cancer in children; or (iii) seek to discover new therapies or regimens for the treatment of cancer in children which are more cost effective than standard therapies or regimens. Such program must be certified by and utilize the standards for acceptable protocols established by the Pediatric Oncology Group or Children's Cancer Group.

"Routine patient care costs" means those medically necessary costs of blood tests, X-rays, bone scans, magnetic resonance images, patient visits, hospital stays, or other similar costs generally incurred by the insured party in connection with the provision of goods, services, or benefits to dependent children under an approved clinical trial program for treatment of children's cancer which otherwise would be covered under the supplemental medical accident and sickness insurance benefit plan, policy, or contract if such medically necessary costs were not incurred in connection with an approved clinical trial program for treatment of children's cancer. Routine patient care costs specifically shall not include the costs of any clinical trial therapies, regimens, or combinations thereof, any drugs or pharmaceuticals, any costs associated with the provision of any goods, services, or benefits to dependent children which generally are furnished without charge in connection with such an approved clinical trial program for treatment of children's cancer, any additional costs associated with the provision of any goods, services, or benefits which previously have been provided to the Dependent child, paid for, or reimbursed, or any other similar costs.

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

#### **BENEFITS FOR BONE MARROW TRANSPLANTS**

Benefits will be paid the same as any other Sickness for bone marrow transplants.

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

## BENEFITS FOR POSTPARTUM CARE

Benefits for a mother and her newly born child will be paid the same as any other Sickness for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section.

Any decisions to shorten the length of stay to less than the minimum specified above shall be made by the attending Physician, obstetrician, or certified nurse midwife after conferring with the mother. If a mother and her newborn are discharged prior to the minimum inpatient stay length specified above, then coverage shall be provided for up to two follow-up visits, provided that the first visit shall occur within 48 hours after discharge. Such visits shall be conducted by a Physician, a physician assistant, or a registered professional nurse with experience and training in maternal and child health nursing.

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

## BENEFITS FOR TREATMENT OF BURNS

Benefits will be paid the same as any other Sickness for the treatment of burns using skin substitutes utilizing cryopreserved cadaver derived skin tissue.

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

## BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

Benefits will be paid for prescribed, orally administered anticancer medications on a basis that is no less favorable than intravenously administered or injected chemotherapy.

The total Copayment and Coinsurance an Insured Person is required to pay shall not exceed \$200 for an individual prescription of up to a 31-day supply per prescription.

Benefits shall be subject to all Deductible, limitations, and any other provision of the policy.

## Coordination of Benefits Provision

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

## Definitions

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**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 of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

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

1. Incapable of self-sustaining employment by reason of developmental disability or physical disability as determined by the Department of Behavioral Health and Developmental Disabilities.
2. Chiefly dependent upon the Insured Person for support and maintenance.

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

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

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

**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 services; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

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

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

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

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

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

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

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

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

**MEDICAL EMERGENCY** means the occurrence of a 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.

**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. A newly born child of the Insured shall include an adopted child. The coverage for the adopted child shall be effective from the date of placement for adoption or final decree of adoption, whichever occurs first. 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.

**NURSE** means a Registered Nurse (R.N.) who is not a member of the Insured Person's immediate family; or, when a Registered Nurse is not available and upon the recommendation of the attending Physician, a Licensed Practical Nurse (L.P.N.) who is not a member of the Insured Person's immediate family.

**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.

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

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



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

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

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

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

## **Exclusions and Limitations**

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

1. Biofeedback.
2. 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 of a Newborn or adopted Infant.
3. Dental treatment, except:
  - For accidental Injury to Sound, Natural Teeth.
  - As described under Dental Treatment in the policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
4. Elective Surgery or Elective Treatment.
5. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
6. Foot care for the following:
  - Flat foot conditions.
  - Supportive devices for the foot, except as specifically provided in Benefits for the Management and Treatment of Diabetes.
  - Fallen arches.
  - Weak feet.
  - Chronic foot strain.
  - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
7. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:

  - Hearing defects or hearing loss as a result of an infection or Injury.
8. Hirsutism. Alopecia.
9. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
10. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
11. Injury sustained while:
  - Participating in any intercollegiate, or professional sport, contest or competition.
  - Traveling to or from such sport, contest or competition as a participant.
  - Participating in any practice or conditioning program for such sport, contest or competition.
12. Investigational services.
13. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.

14. 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.
  - Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
  - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the policy.
  - 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.
  - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
15. Reproductive/Infertility services including but not limited to the following:
  - Procreative counseling.
  - Genetic counseling and genetic testing.
  - Cryopreservation of reproductive materials. Storage of reproductive materials.
  - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
  - Premarital examinations.
  - Impotence, organic or otherwise.
  - Female sterilization procedures, except as specifically provided in the policy.
  - Vasectomy.
  - Reversal of sterilization procedures.
  - Sexual reassignment surgery.
16. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.  
This exclusion does not apply as follows:
  - When due to a covered Injury or disease process.
  - To benefits specifically provided in Pediatric Vision Services.
  - To benefits specifically provided under Vision Correction in the policy.
  - To lenses following surgical removal of the lenses of the eye.
17. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
18. Deviated nasal septum, including submucous resection and/or other surgical correction thereof.
19. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
20. Sleep disorders.
21. Speech therapy, 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. 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 and minor child(ren) are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

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

The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

**Key Services include:**

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to \$5,000.00 payment (when included with your enrollment in an UnitedHealthcare **Student**Resources health insurance policy)
- Facilitation of Hospital Admission Payments (when Global Emergency Services is purchased as a stand-alone supplement)
- 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:

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

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at [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.

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## 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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## Claim Procedures for Injury and Sickness Benefits

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In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number (insured's insurance company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

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

## **Pediatric Dental Services Benefits**

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Benefits are provided for Covered Dental Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) 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 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.

| <b>Benefit Description and Limitations</b>   | <b>Network Benefits<br/>Benefits are shown as a<br/>percentage of Eligible<br/>Dental Expenses.</b> | <b>Non-Network Benefits<br/>Benefits are shown as a<br/>percentage of Eligible<br/>Dental Expenses.</b> |
|--|---|---|
| <b>Diagnostic Services</b>   |   |   |
| Intraoral Bitewing Radiographs (Bitewing X-ray)<br><br>Limited to 2 series of films per 12 months.   | 60%   | 60%   |
| Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)<br><br>Limited to 1 time per 36 months.   | 60%   | 60%   |
| Periodic Oral Evaluation (Checkup Exam)<br><br>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. | 60%   | 60%   |
| <b>Preventive Services</b>   |   |   |
| Dental Prophylaxis (Cleanings)<br><br>Limited to 2 times per 12 months.  | 60%   | 60%   |
| Fluoride Treatments<br><br>Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.   | 60%   | 60%   |

| <b>Benefit Description and Limitations</b>   | <b>Network Benefits<br/>Benefits are shown as a percentage of Eligible Dental Expenses.</b> | <b>Non-Network Benefits<br/>Benefits are shown as a percentage of Eligible Dental Expenses.</b> |
|--|---|---|
| Sealants (Protective Coating)<br><br>Limited to once per first or second permanent molar every 36 months.  | 60%   | 60%   |
| <b>Space Maintainers</b>   |   |   |
| Space Maintainers (Spacers)<br><br>Benefit includes all adjustments within 6 months of installation.   | 60%   | 60%   |
| <b>Minor Restorative Services, Endodontics, Periodontics and Oral Surgery</b>  |   |   |
| Amalgam Restorations (Silver Fillings)<br><br>Multiple restorations on one surface will be treated as a single filling.  | 60%   | 60%   |
| Composite Resin Restorations (Tooth Colored Fillings)<br><br>For anterior (front) teeth only.  | 60%   | 60%   |
| Endodontics (Root Canal Therapy)   | 60%   | 60%   |
| Periodontal Surgery (Gum Surgery)<br><br>Limited to 1 quadrant or site per 36 months per surgical area.  | 60%   | 60%   |
| Scaling and Root Planing (Deep Cleanings)<br><br>Limited to 1 time per quadrant per 24 months.   | 60%   | 60%   |
| Periodontal Maintenance (Gum Maintenance)<br><br>Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.  | 60%   | 60%   |
| Simple Extractions (Simple tooth removal)<br><br>Limited to 1 time per tooth per lifetime.   | 60%   | 60%   |
| Oral Surgery, including Surgical Extraction  | 60%   | 60%   |
| <b>Adjunctive Services</b>   |   |   |
| General Services (including Dental Emergency treatment)<br><br>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.<br><br>Occlusal guards limited to 1 guard every 12 months. | 60%   | 60%   |
| <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.  |   |   |
| Inlays/Onlays/Crowns (Partial to Full Crowns)<br><br>Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.  | 60%   | 60%   |
| Fixed Prosthetics (Bridges)<br><br>Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.  | 60%   | 60%   |

| <b>Benefit Description and Limitations</b>   | <b>Network Benefits<br/>Benefits are shown as a percentage of Eligible Dental Expenses.</b> | <b>Non-Network Benefits<br/>Benefits are shown as a percentage of Eligible Dental Expenses.</b> |
|--|---|---|
| Removable Prosthetics (Full or partial dentures)<br><br>Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.  | 60%   | 60%   |
| Relining and Rebasing Dentures<br><br>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.  | 60%   | 60%   |
| Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns<br><br>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.   | 60%   | 60%   |
| <b>Implants</b>  |   |   |
| Implant Placement<br><br>Limited to 1 time per 60 months.  | 60%   | 60%   |
| Implant Supported Prosthetics<br><br>Limited to 1 time per 60 months.  | 60%   | 60%   |
| Implant Maintenance Procedures<br><br>Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.  | 60%   | 60%   |
| Repair Implant Supported Prosthesis by Report<br><br>Limited to 1 time per 60 months.  | 60%   | 60%   |
| Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium<br><br>Limited to 1 time per 60 months.   | 60%   | 60%   |
| Repair Implant Abutment by Support<br><br>Limited to 1 time per 60 months.   | 60%   | 60%   |
| Radiographic/Surgical Implant Index by Report<br><br>Limited to 1 time per 60 months.  | 60%   | 60%   |
| <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.<br><br>All orthodontic treatment must be prior authorized. |   |   |
| Orthodontic Services<br><br>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.   | 60%   | 60%   |



### **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.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. 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.

**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. | 70% of the billed charge.  |
| <b>Eyeglass Lenses</b>   | Once per year.       |                                 |                            |
| • Single Vision  |                      | 100% after a Copayment of \$40. | 70% of the billed charge.  |
| • Bifocal  |                      | 100% after a Copayment of \$40. | 70% of the billed charge.  |
| • Trifocal   |                      | 100% after a Copayment of \$40. | 70% of the billed charge.  |
| • Lenticular   |                      | 100% after a Copayment of \$40. | 70% 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>Vision Care Service</b>  | <b>Frequency of Service</b>   | <b>Network Benefit</b>          | <b>Non-Network Benefit</b> |
|---|-------------------------------|---------------------------------|----------------------------|
| <b>Eyeglass Frames</b>  | Once per year.                |                                 |                            |
| <ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost up to \$130.</li> </ul>   |                               | 100%                            | 70% of the billed charge.  |
| <ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost of \$130 – 160.</li> </ul>  |                               | 100% after a Copayment of \$15. | 70% of the billed charge.  |
| <ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost of \$160 – 200.</li> </ul>  |                               | 100% after a Copayment of \$30. | 70% of the billed charge.  |
| <ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost of \$200 – 250.</li> </ul>  |                               | 100% after a Copayment of \$50. | 70% of the billed charge.  |
| <ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost greater than \$250.</li> </ul>  |                               | 60%                             | 70% of the billed charge.  |
| <b>Contact Lenses</b>   | Limited to a 12 month supply. |                                 |                            |
| <ul style="list-style-type: none"> <li>• Covered Contact Lens Selection</li> </ul>  |                               | 100% after a Copayment of \$40. | 70% of the billed charge.  |
| <ul style="list-style-type: none"> <li>• Necessary Contact Lenses</li> </ul>  |                               | 100% after a Copayment of \$40. | 70% of the billed charge.  |
| <b>Low Vision Services</b>  | Once every 24 months.         |                                 |                            |
| 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. |                               |                                 |                            |
| <ul style="list-style-type: none"> <li>• Low Vision Testing</li> </ul>  |                               | 100% of the billed charge.      | 75% of the billed charge.  |
| <ul style="list-style-type: none"> <li>• Low Vision Therapy</li> </ul>  |                               | 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):

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):

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 1-866-403-8267 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 of care, or effectiveness.

#### **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**

In the event that the health condition of the Insured Person is such that completing a Standard External Review would jeopardize the life or health of the Insured Person or the Insured Person's ability to regain maximum function, as determined by the Insured Person's treating Physician, an expedited external review shall be available.

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

All types of External Review requests shall be submitted on the state's required Independent Review request form to the Georgia Department of Community Health at the following address:

Attention: Independent Review Requests  
Office of General Counsel/Division of Health Planning  
Georgia Department of Community Health  
2 Peachtree Street NW  
5th Floor  
Atlanta, Georgia 30303-3142  
(404) 656-0409  
<http://dch.georgia.gov>

### **Questions Regarding Appeal Rights**

Contact Customer Service at 1-866-403-8267 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:

Georgia Office of Insurance and Safety Fire Commissioner  
Consumer Services Division  
2 Martin Luther King, Jr. Drive  
West Tower, Suite 716  
Atlanta, GA 30334  
(800) 656-2298  
<http://www.oci.ga.gov/ConsumerService/Home.aspx>

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

Administrative Office:  
UnitedHealthcare **Student**Resources  
P.O. Box 809025  
Dallas, Texas 75380-9025  
866-403-8267

Sales/Marketing Services:  
UnitedHealthcare **Student**Resources  
805 Executive Center Drive West, Suite 220  
St. Petersburg, FL 33702  
800-237-0903  
E-mail: [info@uhcsr.com](mailto:info@uhcsr.com)

For information on Dental and Vision Plans that may be available, please call 866-403-8267 or visit the Website at [www.uhcsr.com/usg](http://www.uhcsr.com/usg).

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the College 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 # 2016-200289-1.

