

*Certificate of Coverage*



## 2016–2017 Student Injury and Sickness Insurance Plan

*Designed Especially for the Students of*



PLEASE NOTE:

THIS DOCUMENT HAS  
CHANGED. PLEASE SEE THE  
BACK COVER FOR DETAILS

### MAJOR MEDICAL EXPENSE COVERAGE

Read your Policy carefully – This document provides a brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The master policy itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Underwritten by UnitedHealthcare Insurance Company  
Home Office: 450 Columbus Boulevard, Hartford, CT 06115



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## **Privacy Policy**

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

## **Eligibility**

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Undergraduate students enrolled for six (6) or more credit hours each semester and graduate students enrolled in three (3) or more credit hours are eligible to enroll in this insurance Plan. All full-time degree seeking international students with F1 or J1 visas are automatically enrolled in this insurance plan, unless proof of comparable coverage is furnished. Students enrolled in online classes, with a minimum of three (3) credit hours on campus are eligible to enroll in the plan. Eligible graduate students for the University of Utah subsidized graduate plan include research and teaching assistants.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study and correspondence 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 16, 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., August 15, 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.

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 30 days after the coverage expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

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

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

## Premium Rates

Period:	Annual	Fall	Spring / Summer	Summer
Dates:	8/16/16 to 8/15/17	8/16/16 to 12/31/16	1/1/17 to 8/15/17	5/12/17 to 8/15/17
Open Enrollment Dates:	7/15/16 to 9/13/16	7/15/16 to 9/13/16	12/2/16 to 2/10/17	5/1/17 to 5/31/17
Rates:				
Student	\$1,847	\$ 698	\$1,149	\$ 486
Spouse	\$1,836	\$ 694	\$1,142	\$ 483
One Child	\$1,836	\$ 694	\$1,142	\$ 483
Two or More Children	\$3,672	\$1,388	\$2,284	\$ 966
Spouse + Two or More Children	\$5,508	\$2,082	\$3,426	\$1,449

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

## Student Health Center (SHC)

**What:** The Student Health Center is a medical clinic located on campus. It specializes in college health issues and is designed specifically for students and their dependents. All students pay a health fee that helps support SHC and allows its charges to be 40-60% less than what a private provider will charge.

SHC makes every effort to have appointments available that are easily coordinated with classes, work and/or family schedules.

**Who:** SHC staff includes physicians and nurse practitioners who specialize in primary care, family medicine, and pediatrics.

**Services:** Most sicknesses, injuries and preventive care can be obtained at SHC. Sports medicine, women's, men's, and children's preventive health services, family planning, wellness exams, and minor Injury treatment are among the many services available.

Radiology and laboratory services are also available onsite. Although not part of the Student Health Center, pharmacy services are available on the third floor of Madsen Clinics in the same building.

Other services available include: Travel vaccinations, childhood and adult immunizations, confidential HIV and STD testing and counseling, health promotion and education, stress and anxiety support, and pediatric and parenting services.

**Location:** The Student Health Center is located on campus in the basement of the Madsen Health Center (555 Foothill Drive) on the corner of Foothill Drive and Mario Capecchi Drive. Patient parking is available free of charge, or TRAX and the campus shuttle can be used to reach the clinic.

### Hours Open:

7:30 a.m. – 5:00 p.m. Monday through Friday

9:00 a.m. – Noon Saturday

During Fall and Spring semesters, Tuesday clinic hours are extended until 7:30 p.m.

### Hours Closed:

Every Wednesday from 12 noon until 2:00 p.m.

All University of Utah holidays and University Closure Days.

All Saturdays that fall before a Monday holiday, after a Friday holiday, and during breaks.

When the Student Health Center is closed, insured students are encouraged to call the Nurseline and Student Assistance available 24/7, 365 days per year. The Nurseline and Student Assistance phone number is posted on the insurance ID card. Calls will be answered by a registered nurse and provide guidance regarding treatment.

**Appointments:** Always recommended to ensure that you will be seen at a time that works with your schedule. If you call early in the day, you can usually get an appointment that afternoon. Every attempt is made to have "same day" or "next day" appointments available. For an appointment call 1-801-581-6431.

Walk-ins: If you walk-in without an appointment, you will probably have to wait to talk with a nurse. If you are injured or are extremely sick, a nurse will work you into the provider schedule or refer you to the University Hospital Emergency Department.

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

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The student and Spouse/Dependents should use the services of the Health Center first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained will be paid at 55% of the benefits otherwise payable under the Schedule of Benefits. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

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

1. Medical Emergency. The student must return to SHC for necessary follow-up care.
2. When the Student Health Center is closed.
3. Medical care received when the student is more than 25 miles from campus.
4. Maternity, obstetrical and gynecological care.
5. Mental Illness treatment and Substance Use Disorder treatment.

## **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:

University Health Sciences Center, University Hospital and Primary Children's Medical Center and UnitedHealthcare Options PPO (In-Network).

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

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

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

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

**Inpatient Expenses**

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

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

**Outpatient Hospital Expenses**

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

**Professional & Other Expenses**

Benefits for Covered Medical Expenses provided by University Health Sciences Center, University Hospital and Primary Children’s Medical Center and UnitedHealthcare Options PPO (In-Network) 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 78.530 %**

**Injury and Sickness Benefits**

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

Deductible Preferred Providers	\$250 (Per Insured Person, Per Policy Year)
Deductible Preferred Providers	\$500 (For all Insureds in a Family, Per Policy Year)
Deductible In-Network Providers	\$500 (Per Insured Person, Per Policy Year)
Deductible In-Network Providers	\$1,000 (For all Insureds in a Family, Per Policy Year)
Deductible Out-of-Network	\$1,000 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network	\$2,000 (For all Insureds in a Family, Per Policy Year)
Coinsurance Preferred Providers	80% except as noted below
Coinsurance In-Network Providers	65% except as noted below
Coinsurance Out-of-Network	55% except as noted below
Out of Pocket Maximum	\$4,000 (Per Insured Person, Per Policy Year)
Out of Pocket Maximum	\$8,000 (Per all Insureds in a Family, Per Policy Year)

The Preferred Provider for this plan is University Health Sciences Center, University Hospital and Primary Children's Medical Center. The In-Network Provider for this plan is UnitedHealthcare Options PPO.

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

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. 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.

**Student Health Center Benefits:** The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses after a \$10 Copay per visit (except for preventive care) when treatment is rendered at the Student Health Center. Testing/screening for HIV and Sexually Transmitted Diseases that do not meet the Preventive Service Task Force Guidelines, are covered at 100% when treatment is rendered at the Student Health Center.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider, In-Network 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	In-Network Provider	Out-of-Network Provider
<b>Room and Board Expense</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Intensive Care</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Hospital Miscellaneous Expenses</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Routine Newborn Care</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Surgery</b> If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Assistant Surgeon Fees</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Anesthetist Services</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Registered Nurse's Services</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Physician's Visits</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Pre-admission Testing</b> Payable within 7 working days prior to admission.	Preferred Allowance	Preferred Allowance	Usual and Customary Charges

<b>Outpatient</b>	<b>Preferred Provider</b>	<b>In-Network Provider</b>	<b>Out-of-Network Provider</b>
<b>Surgery</b> If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Day Surgery Miscellaneous</b> Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Assistant Surgeon Fees</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Anesthetist Services</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Physician's Visits</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Physiotherapy</b> Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Medical Emergency Expenses</b> The Copay/per visit Deductible will be waived if admitted to the Hospital. The Copay/per visit Deductible is in addition to the Policy Deductible. Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.	Preferred Allowance \$150 Copay per visit	80% of Preferred Allowance \$150 Copay per visit	80% of Usual and Customary Charges \$150 Deductible per visit
<b>Diagnostic X-ray Services</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Radiation Therapy</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Laboratory Procedures</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Tests &amp; Procedures</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Injections</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Chemotherapy</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Prescription Drugs</b> The Policy Deductible is waived.	50% of Preferred Allowance	50% of Preferred Allowance	50% of Usual and Customary Charges

<b>Other</b>	<b>Preferred Provider</b>	<b>In-Network Provider</b>	<b>Out-of-Network Provider</b>
<b>Ambulance Services</b>	Preferred Allowance	80% of Preferred Allowance	80% of Usual and Customary Charges
<b>Durable Medical Equipment</b>	60% of Preferred Allowance	60% of Preferred Allowance	60% of Usual and Customary Charges
<b>Consultant Physician Fees</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges



Other	Preferred Provider	In-Network Provider	Out-of-Network Provider
<b>Dental Treatment</b> Benefits paid on Injury to Sound, Natural Teeth only.	Preferred Allowance	80% of Preferred Allowance	80% of Usual and Customary Charges
<b>Mental Illness Treatment</b>	Paid as any other Sickness	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	Paid as any other Sickness
<b>Maternity</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Complications of Pregnancy</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Elective Abortion</b> The elective abortion exclusion will be waived and benefits will be paid only for reasons of rape or incest or when the life of the mother is endangered.	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Preventive Care Services</b> No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. 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 Preferred Allowance	75% of Usual and Customary Charges
<b>Reconstructive Breast Surgery Following Mastectomy</b> See Benefits for Mastectomy Breast Surgery, Reconstruction, and Prosthesis.	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Diabetes Services</b> See Benefits for Diabetes Treatment.	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Home Health Care</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Hospice Care</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Inpatient Rehabilitation Facility</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Skilled Nursing Facility</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Urgent Care Center</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Hospital Outpatient Facility or Clinic</b>	Preferred Allowance	Preferred Allowance	Usual and Customary Charges
<b>Approved Clinical Trials</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
<b>Transplantation Services</b>	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness

## 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.**

See Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**

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

Benefits will be paid for services and supplies such as:

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

4. **Routine Newborn Care.**

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

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

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

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

5. **Surgery (Inpatient).**

Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**

Professional services administered in connection with Inpatient surgery.

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

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

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

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

9. **Physician's Visits (Inpatient).**  
Non-surgical Physician services when confined as an Inpatient.

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.

When these services are performed in a Physician's office, benefits are payable under Physician's Visits (Outpatient).

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 Physiotherapy.

Benefits include the following services when performed in the Physician's office:

- Surgery.

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.

**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.
- One pair of ear plugs within 60 days following an ear surgery covered under the policy.

If more than one piece of equipment or device can meet the Insured's functional need, 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.

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

29. **Mental Illness Treatment.**

Benefits will be paid for services received:

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

30. **Substance Use Disorder Treatment.**

Benefits will be paid for services received:

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

31. **Maternity.**

Same as any other Sickness.

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

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

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

32. **Complications of Pregnancy.**

Same as any other Sickness.

33. **Preventive Care Services.**

Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

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

- Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Mastectomy Breast Surgery, Reconstruction and Prostheses.

35. **Diabetes Services.**
- Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes Treatment.
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.

**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.

## **Mandated Benefits**

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### **BENEFITS FOR INBORN ERRORS OF METABOLISM**

Benefits will be paid the same as any other Sickness for Dietary Products used for the treatment of Inborn Errors of Amino Acid or Urea Cycle Metabolism. Inborn errors of amino acid or urea cycle metabolism means a disease caused by an inherited abnormality of body chemistry which is treatable by the dietary restriction of one or more amino acid.

Dietary products means medical food or a low protein modified food product that is all of the following:

- 1) Specifically formulated to treat Inborn Errors of Amino Acid or Urea Cycle Metabolism;
- 2) Not a natural food that is naturally low in protein.
- 3) Used under the direction of a Physician.

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

### **BENEFITS FOR ADOPTION INDEMNITY**

Benefits will be provided for \$4,000.00 payable to the Insured when an adopted child is placed for adoption with the Insured within 90 days of the child’s birth. The Insured Person must be covered by this policy on the date of the adoptive placement. If more than one child from the same birth is placed for adoption with the insured, only one adoption indemnity benefit is required. The full amount of the benefit shall be refunded to the Company if the post placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of the adoptive parent or parents that affects the child’s health or safety.

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

**NOTICE: This plan does not allow an exchange of the adoption indemnity benefit for infertility treatments.**

## **BENEFITS FOR DIABETES TREATMENT**

Benefits will be paid the same as any other Sickness for treatment, services and supplies for diabetes. "Diabetes" includes:

- 1) Complete insulin deficiency or type 1 diabetes.
- 2) Insulin resistant with partial insulin deficiency or type 2 diabetes.
- 3) Elevated blood glucose levels induced by pregnancy or gestational diabetes.

Benefits will be paid for the following:

- 1) Diabetes self-management training and patient management, including medical nutrition therapy as defined by rule, provided by an accredited or certified program and referred by a Physician within the plan and consistent with the health plan provisions for self-management education that is either:
  - a) Recognized by the federal Health Care Financing Agency.
  - b) Certified by the Department of Health.
- 2) The following equipment, supplies, and appliances to treat diabetes when Medically Necessary:
  - a) Blood glucose monitors, including those for the legally blind.
  - b) Test strips for blood glucose monitors.
  - c) Visual reading urine and ketone strips.
  - d) Lancets and lancet devices.
  - e) Insulin.
  - f) Injection aides, including those adaptable to meet the needs of the legally blind, and infusion delivery systems.
  - g) Syringes.
  - h) Prescriptive oral agents for controlling blood glucose levels.
  - i) Glucagon kits.

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

## **BENEFITS FOR MASTECTOMY, BREAST SURGERY, RECONSTRUCTION AND PROSTHESES**

Benefits will be paid the same as any other Sickness for an Insured who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy. Benefits will be provided in a manner determined in consultation with the Physician and the Insured for the following:

- 1) Reconstruction of the breast on which the mastectomy has been performed.
- 2) Surgery and reconstruction of the breast on which the mastectomy was not performed to produce symmetrical appearance.
- 3) Prostheses and physical complications with regards to all stages of mastectomy, including lymphedemas.

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

## **BENEFITS FOR AUTISM SPECTRUM DISORDER**

Benefits will be paid the same as any other Sickness for the treatment of Autism Spectrum Disorder. For the purposes of this benefit, "treatment" includes diagnosis, assessment, evaluations or tests, pharmacy care, psychiatric or psychological care, therapeutic care and services.

"Autism Spectrum Disorder" means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Benefits will be paid the same as for any other Sickness for Behavioral Health Treatment for Autism Spectrum Disorder provided to an Insured Person who is at least 2 years old, but younger than 10 years old. Behavioral Health Treatment must be provided or supervised by a licensed or certified Physician or a board certified behavior analyst.



“Behavioral Health Treatment” means counseling and treatment programs, including applied behavior analysis, that are:

- 1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- 2) Provided or supervised by a board certified behavior analyst, or a person whose scope of practice includes mental health services.

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

We may request a treatment plan from the provider recommending treatment.

## **Coordination of Benefits Provision**

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

## **Accidental Death and Dismemberment Benefits**

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

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

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

Life	\$10,000
Both Hands, Both Feet, or Sight of Both Eyes	\$ 7,500
One Hand and One Foot	\$ 7,500
Either One Hand or One Foot and Sight of One Eye	\$ 7,500
One Hand or One Foot or Sight of One Eye	\$ 5,000
Entire Thumb and Index Finger of Either Hand	\$ 2,500

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

## **Continuation Privilege**

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All Insured Persons who have been continuously insured under the school's regular student Policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 6 months under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

## **Definitions**

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**ADOPTED CHILD** means the adopted child placed with the Named Insured while that person is covered under this policy. Such child will be covered beginning from the moment of birth if placement for adoption occurs within 31 days of the child's birth or beginning from the date of placement if placement for adoption occurs 31 days or more after the child's birth.

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

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

**COMPLICATION OF PREGNANCY** means diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy. The term "complication of pregnancy" includes acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia and toxemia. The term "complication of pregnancy" shall not include false labor, occasional spotting, doctor-prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult 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 mental retardation or physical handicap.
2. Chiefly dependent upon the Insured Person for support and maintenance.

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

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

**ELECTIVE SURGERY OR ELECTIVE TREATMENT** as defined by the Company 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 an institution duly licensed as a hospital and operating within the scope of such license.

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

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

1. the direct cause of the condition.
2. independent and 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 the accident or as soon as reasonably possible.
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.

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

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

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

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

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

**MEDICAL EMERGENCY** means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**POLICY YEAR** means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

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

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

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

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

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

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

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

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

## **Exclusions and Limitations**

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

1. Acupuncture.
2. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Intensive behavioral therapies, such as applied behavioral analysis. Learning disabilities. Milieu therapy. Parent-child problems  
This exclusion does not apply as specifically provided in Benefits for Autism Spectrum Disorder.
3. Biofeedback.
4. Circumcision.
5. 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.
  - Restore bodily function to an abnormal structure of the body caused by a congenital defect or developmental abnormality.

This exclusion does not apply as specifically provided for Benefits for Mastectomy, Breast Surgery, Reconstruction and Prostheses.

6. Custodial Care.
  - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
  - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.

7. Dental treatment, except:
  - For accidental Injury to Sound, Natural Teeth.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Elective abortion.
10. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
11. Foot care for the following:
  - Flat foot conditions.
  - Supportive devices for the foot.
  - 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.
12. Health spa or similar facilities. Strengthening programs.
13. 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.
14. Hypnosis.
15. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
17. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance or under a no-fault automobile insurance policy.
18. Injury sustained while:
  - Participating in any high school, 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.
19. Investigational services.
20. Lipectomy.
21. Marital or family counseling.
22. Active participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.
23. 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.
  - 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.
24. 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.
  - Fertility tests.
  - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
  - Premarital examinations.
  - Impotence, organic or otherwise.
  - Female sterilization procedures, except as specifically provided in the policy.

- Vasectomy.
  - Reversal of sterilization procedures.
25. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.
  26. 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 one lens for the affected eye following corneal transplant surgery and contact lenses for the Medically Necessary treatment of keratoconus.
  27. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
  28. Preventive care services, except as specifically provided in the policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.
  29. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
  30. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Temporomandibular joint dysfunction. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
  31. Speech therapy, except as specifically provided in the policy. Naturopathic services.
  32. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
  33. Supplies, except as specifically provided in the policy.
  34. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
  35. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
  36. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
  37. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.

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

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

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

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 a UnitedHealthcare **StudentResources** 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.

## 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.

## **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.

## **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.

## **UnitedHealth Allies**

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

## **Claim 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 Wellness Center 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 or as soon as reasonably possible.

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 Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
<b>Diagnostic Services</b>		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	50%	50%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	50%	50%
Periodic Oral Evaluation (Checkup Exam) Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.	50%	50%
<b>Preventive Services</b>		
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	50%	50%
Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50%	50%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	50%	50%
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	50%	50%
<b>Minor Restorative Services, Endodontics, Periodontics and Oral Surgery</b>		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50%	50%
Endodontics (Root Canal Therapy)	50%	50%

<b>Benefit Description and Limitations</b>	<b>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
Periodontal Surgery (Gum Surgery) Limited to 1 quadrant or site per 36 months per surgical area.	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.	50%	50%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50%	50%
Oral Surgery, including Surgical Extraction	50%	50%
<b>Adjunctive Services</b>		
General Services (including Dental Emergency treatment)  Covered as a separate benefit only if no other service was done during the visit other than X-rays.  General anesthesia is covered when clinically necessary. Occlusal guards limited to 1 guard 12 months.	50%	50%
<b>Major Restorative Services</b>		
Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebasings Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	50%	50%
<b>Implants</b>		
Implant Placement Limited to 1 time per 60 months.	50%	50%
Implant Supported Prosthetics Limited to 1 time per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	50%	50%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium Limited to 1 time per 60 months.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Repair Implant Abutment by Support Limited to 1 time per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	50%	50%
<b>MEDICALLY NECESSARY ORTHODONTICS</b>		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.		
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	50%	50%

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

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
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 or as soon as reasonably possible.

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.	50% of the billed charge.
<b>Eyeglass Lenses</b>	Once per year.		
• Single Vision		100% after a Copayment of \$40.	50% of the billed charge.
• Bifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Trifocal		100% after a Copayment of \$40.	50% of the billed charge.

<b>Vision Care Service</b>	<b>Frequency of Service</b>	<b>Network Benefit</b>	<b>Non-Network Benefit</b>
<ul style="list-style-type: none"> <li>Lenticular</li> </ul>		100% after a Copayment of \$40.	50% of the billed charge.
<b>Lens Extras</b>	Once per year.		
<ul style="list-style-type: none"> <li>Polycarbonate Lenses</li> </ul>		100%	100% of billed charges.
<ul style="list-style-type: none"> <li>Standard scratch-resistant coating</li> </ul>		100%	100% of billed charges.
<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%	50% 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.	50% 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.	50% 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.	50% of the billed charge.
<ul style="list-style-type: none"> <li>Eyeglass frames with a retail cost greater than \$250.</li> </ul>		60%.	50% 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.	50% of the billed charge.
<ul style="list-style-type: none"> <li>Necessary Contact Lenses</li> </ul>		100% after a Copayment of \$40.	50% of the billed charge.
<b>Low Vision Services</b>			
Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Services, the Insured will be required to pay all billed charges at the time of service. The Insured may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
<ul style="list-style-type: none"> <li>Low Vision Testing</li> </ul>		100% of the billed charges.	75% of the billed charge.
<ul style="list-style-type: none"> <li>Low Vision Therapy</li> </ul>		100% of the billed charges.	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 or as soon as reasonably possible.

### **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 800-767-0700 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 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**

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

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

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

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

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

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

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

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

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

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

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

### **Questions Regarding Appeal Rights**

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

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:

Utah Insurance Department  
Office of Consumer Health Assistance  
State Office Building, Suite 3110  
Salt Lake City, UT 84114  
(801) 538-3077  
Healthappeals.uid@utah.gov

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

Administrative Office:  
UnitedHealthcare **Student**Resources  
P.O. Box 809025  
Dallas, Texas 75380-9025  
800-767-0700

Sales/Marketing Services:  
UnitedHealthcare **Student**Resources  
805 Executive Center Drive West, Suite 220  
St. Petersburg, FL 33702  
727-563-3400  
800-237-0903  
E-mail: info@uhcsr.com

For information on Dental and Vision Plans that may be available, please call 800-237-0903 or visit the Website at [www.uhcsr.com](http://www.uhcsr.com)

**Online Services:** Please visit our Website at [www.uhcsr.com/utah](http://www.uhcsr.com/utah) to buy insurance online, or to view and print Certificates, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services.

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

This Certificate is based on Policy # 2016-2310-1.



# University of Utah

POLICY NUMBER: 2016-2310-1

**NOTICE:**

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

NOC - 08/31/2016

NOC #1 8/31/2016

**Policy:**

Removed separate OOP Max for Preferred Provider and Out of Network and made one combined OOP Max of \$4,000 (Per Insured Person, Per Policy Year) and \$8,000 (For all Insureds in a Family, Per Policy Year). Now showing as

OOP Maximum \$4,000 (Per Insured Person, Per Policy Year)

OOP Maximum \$8,000 (For all Insureds in a Family, Per Policy Year)

**Brochure:**

Removed separate OOP Max for Preferred Provider and Out of Network and made one combined OOP Max of \$4,000 (Per Insured Person, Per Policy Year) and \$8,000 (For all Insureds in a Family, Per Policy Year). Now showing as

OOP Maximum \$4,000 (Per Insured Person, Per Policy Year)

OOP Maximum \$8,000 (For all Insureds in a Family, Per Policy Year)

**Summary Brochure:**

Removed separate OOP Max for Preferred Provider/In-Network and Out of Network and made one combined OOP Max of \$4,000 (Per Insured Person, Per Policy Year) and \$8,000 (For all Insureds in a Family, Per Policy Year). Now showing as

OOP Maximum \$4,000 (Per Insured Person, Per Policy Year)

OOP Maximum \$8,000 (For all Insureds in a Family, Per Policy Year)