



# 2013-2014

## STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of



GEORGE FOX  
UNIVERSITY

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



## **Notice Regarding Your Student Health Insurance Coverage**

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2012 and \$500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of \$500,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-767-0700. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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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 800-767-0700 or visiting us at [www.uhcsr.com](http://www.uhcsr.com).

## **Eligibility**

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All full-time students of George Fox University are required to have insurance coverage. Any student with existing health insurance coverage may be exempted from participation in the student plan by completing and filing a waiver form with the University each academic year.

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

## **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, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 15, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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

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

## **Extension of Benefits After Termination**

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

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

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

## **Pre-Admission Notification**

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.

## **Student Health Center Referral**

The student must use the services of the Health and Counseling Center (HCC) first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the HCC for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the HCC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

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

1. Medical Emergency. The student must return to HCC for necessary follow-up care.
2. When the HCC is closed.
3. When service is rendered at another facility during break or vacation periods.
4. Medical care received when the student is more than 10 miles from campus.
5. Medical care obtained when a student is no longer able to use the HCC due to a change in student status.
6. Maternity, obstetrical and gynecological care.

**Schedule of Medical Expense Benefits**  
Injury and Sickness

**Maximum Benefit: \$500,000 Paid As Specified Below**  
(Per Insured Person) (Per Policy Year)

**Deductible Preferred Provider: \$250 (Per Insured Person, Per Policy Year)**

**Deductible Out-of-Network: \$500 (Per Insured Person, Per Policy Year)**

**Coinsurance Preferred Provider: 80% except as noted below**

**Coinsurance Out-of-Network: 60% except as noted below**

**Out-of-Pocket Maximum Preferred Provider:**  
**\$3,500 (Per Insured Person, Per Policy Year)**

**Out-of-Pocket Maximum Out-of-Network:**  
**\$7,000 (Per Insured Person, Per Policy Year)**

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred 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 up to the Maximum Benefit of \$500,000.

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

**Student Health Center Benefits:** The Deductible will be waived when treatment is rendered at the George Fox University Health and Counseling Center (HCC).

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Covered Medical Expenses include:

<b>PA = Preferred Allowance</b>		<b>U&amp;C = Usual &amp; Customary Charges</b>	
<b>INPATIENT</b>		<b>Preferred Providers</b>	<b>Out-of-Network Providers</b>
<b>Room and Board Expense</b> , daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.		80% of PA	60% of U&C
<b>Intensive Care</b>		80% of PA	60% of U&C

INPATIENT	Preferred Providers	Out-of-Network Providers
<b>Hospital Miscellaneous Expense</b> , such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of U&C
<b>Routine Newborn Care</b> , while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
<b>Physiotherapy</b>	80% of PA	60% of U&C
<b>Surgeon's Fees</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.	80% of PA	60% of U&C
<b>Assistant Surgeon</b>	80% of PA	60% of U&C
<b>Anesthetist</b> , professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
<b>Registered Nurse's Services</b> , private duty nursing care.	80% of PA	60% of U&C
<b>Physician's Visits</b> , non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	60% of U&C
<b>Pre-Admission Testing</b> , payable within 7 working days prior to admission.	80% of PA	60% of U&C
OUTPATIENT		
<b>Surgeon's Fees</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.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
<b>Day Surgery Miscellaneous</b> , related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of U&C
<b>Assistant Surgeon</b>	80% of PA	60% of U&C
<b>Anesthetist</b> , professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
<b>Physician's Visits</b> , Benefits do not apply when related to surgery.	80% of PA	60% of U&C
<b>Physiotherapy</b> , Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy, unless excluded in the policy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of PA	60% of U&C
<b>Medical Emergency Expenses</b> , facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. The Copay/per visit Deductible is in addition to the Policy Deductible. (The Copay/per visit Deductible will be waived if admitted to the Hospital.)	80% of PA / \$100 Copay per visit	80% of U&C / \$100 Deductible per visit
<b>Diagnostic X-ray Services</b>	80% of PA	60% of U&C
<b>Radiation Therapy</b>	80% of PA	60% of U&C
<b>Chemotherapy</b>	80% of PA	60% of U&C
<b>Laboratory Services</b>	80% of PA	60% of U&C
<b>Tests &amp; Procedures</b> , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of U&C
<b>Injections</b> , when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C



OUTPATIENT	Preferred Providers	Out-of-Network Providers
<b>Prescription Drugs,</b> (Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.)	UnitedHealthcare Pharmacy (UHCP) \$15 Copay per prescription for Tier 1 \$35 Copay per prescription for Tier 2 \$70 Copay per prescription for Tier 3 up to a 31-day supply per prescription	No Benefits
<b>OTHER</b>		
<b>Ambulance Services</b>	80% of PA	80% of U&C
<b>Durable Medical Equipment,</b> a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. \$1,000 maximum Per Policy Year. <i>(Durable Medical Equipment benefits payable under the \$1,000 maximum are not included in the \$500,000 Maximum Benefit)</i> See also Benefits for Prosthetic and Orthotic Devices and Benefits for Maxillofacial Prosthetic Services.	80% of PA	60% of U&C
<b>Consultant Physician Fees,</b> when requested and approved by attending Physician.	80% of PA	60% of U&C
<b>Dental Treatment,</b> made necessary by Injury to Sound, Natural Teeth only. <i>\$1,000 maximum Per Policy Year. (Benefits are not subject to the \$500,000 Maximum Benefit.)</i>	80% of U&C	80% of U&C
<b>Mental Illness Treatment,</b> services received on an Inpatient and outpatient basis. See Benefits for Substance Use and Mental Illness Coverage.	Paid as any other Sickness	

OTHER	Preferred Providers	Out-of-Network Providers
<p><b>Substance Use Disorder Treatment</b>, services received on an Inpatient and outpatient basis. See Benefits for Substance Use and Mental Illness Coverage.</p>	Paid as any other	Sickness
<p><b>Maternity</b>, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.</p>	Paid as any other	Sickness
<p><b>Complications of Pregnancy</b></p>	Paid as any other	Sickness
<p><b>Elective Abortion</b></p>	No Benefits	
<p><b>Reconstructive Breast Surgery Following Mastectomy</b>, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.</p>	Paid as any other	Sickness
<p><b>Diabetes Services</b>, in connection with the treatment of diabetes for Medically Necessary: 1) outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals; and 2) Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.</p>	Paid as any other	Sickness

OTHER	Preferred Providers	Out-of-Network Providers
<p><b>Preventive Care Services</b>, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the <i>United States Preventive Services Task Force</i>; 2) immunizations that have in effect a recommendation from the <i>Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</i>; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>.</p> <p>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.</p> <p>Information regarding preventive services may be obtained from Customer Service at 1-800-767-0700 and at the following websites:  <a href="http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm">http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm</a> and  <a href="http://www.hrsa.gov/womensguidelines/">http://www.hrsa.gov/womensguidelines/</a></p>	100% of PA	No Benefits

## **UnitedHealthcare Pharmacy Benefits**

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

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

\$15 Copay per prescription order or refill for a Tier 1 Prescription Drug up to 31 day supply.  
\$35 Copay per prescription order or refill for a Tier 2 Prescription Drug up to 31 day supply.  
\$70 Copay per prescription order or refill for a Tier 3 Prescription Drug up to 31 day supply.

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

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

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

### **Additional Exclusions**

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3.
4. Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a prescription order or refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

## Definitions

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

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

## Preferred Provider Information

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

### **UnitedHealthcare Choice Plus.**

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

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

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

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

### **Inpatient Expenses**

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

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

### **Outpatient Hospital Expenses**

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

### **Professional & Other Expenses**

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

## **Maternity Testing**

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

### **Initial screening at first visit:**

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

**Each visit:** Urine analysis

**Once every trimester:** Hematocrit and Hemoglobin

**Once during first trimester:** Ultrasound

**Once during second trimester:**

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

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

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

**Once during third trimester:** Group B Strep Culture

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

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

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

## **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.

## **Mandated Benefits**

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### ***Benefits for Enteral Formula***

Benefits shall be provided on the same basis as any other Sickness for a nonprescription elemental enteral formula for home use, if the formula is Medically Necessary for the treatment of severe intestinal malabsorption and a Physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition.

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

### ***Benefits for Pap Smear Examination***

Benefits shall be provided on the same basis as any other Sickness for a pelvic examination and a Pap Smear examination annually for Insured Persons 18-64, or more often if recommended by a Physician.

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

### ***Benefits for Mammography***

Benefits shall be provided on the same basis as any other Sickness for Insured Persons for (a) mammograms for symptomatic or high-risk Insured Persons at any time upon referral of the Physician; and (b) an annual mammogram for Insured Persons 40 years of age or older, or more often if recommended by a Physician.

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

### ***Benefits for Physical Examination of the Breast***

Benefits shall be provided on the same basis as any other Sickness for a complete and thorough physical examination of the breast for the purpose of early detection and prevention of breast cancer. Benefits include, but are not limited to, a clinical breast examination to check for lumps and other changes.

Physical breast exams shall be provided:

1. Annually for women 18 years of age and older; and
2. At any time at the recommendation of the woman's Physician.

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

### ***Benefits for Prostate Cancer Screening***

Benefits shall be provided on the same basis as any other Sickness for prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test:

1. For Insured men who are 50 years of age or older biennially or as determined by the treating Physician; and
2. For Insured men younger than 50 years of age who are at high risk for prostate cancer as determined by the treating Physician, including African-American men and men with a family medical history of prostate cancer.

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

### ***Benefits for Colorectal Cancer Screening***

Benefits shall be provided on the same basis as any other Sickness for the following colorectal cancer screening examinations and laboratory tests:

1. For an Insured 50 years of age or older:
  - a) One fecal occult blood test per policy year plus one flexible sigmoidoscopy every five years;
  - b) One colonoscopy every 10 years; or
  - c) One double contrast barium enema every five years.
2. For an Insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating Physician.
3. For the purposes of this benefit, an individual is at high risk for colorectal cancer if the individual has: a) A family medical history of colorectal cancer; b) A prior occurrence of cancer or precursor neoplastic polyps; c) A prior occurrence of a chronic digestive disease conditions such as inflammatory bowel disease, Crohn's disease or ulcerative colitis; or d) Other predisposing factors.

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

### ***Benefits for Prosthetic and Orthotic Devices***

Benefits shall be provided on the same basis as any other Sickness for the initial prosthetic and orthotic device and any repair or replacement of the prosthetic or orthotic device that is Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Benefits include all services and supplies necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the Insured in the use of the device.

"Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.

"Prosthetic device" means an artificial limb device or appliance designed to replace, in whole or in part, an arm or a leg.

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

### ***Benefits for Maxillofacial Prosthetic Services***

Benefits shall be provided on the same basis as any other Sickness for maxillofacial prosthetic services considered necessary for adjunctive treatment.

"Maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

1. Controlling or eliminating infection;
2. Controlling or eliminating pain;
3. Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

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



### ***Benefits for Inborn Errors of Metabolism***

Benefits shall be provided on the same basis as any other Sickness for the treatment of inborn error of metabolism that involve amino acids, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

"Medical foods" means foods that are formulated to be consumed or administered entirely under the supervision of a Physician, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein, or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

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

### ***Benefits for Substance Use and Mental Illness Coverage***

Benefits shall be provided on the same basis as any other Sickness for Medically Necessary treatment for chemical dependency, including alcoholism, and for Mental Illness.

"Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For the purpose of this benefit, chemical dependency does not include addiction to or dependence on tobacco, tobacco products, or food.

"Facility" means a provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

"Provider" means a health care facility, a residential program or facility, a day or partial hospitalization program, an outpatient service, or a behavioral health or medical professional authorized for reimbursement under Oregon law.

Nothing in this section requires coverage for:

1. Educational or correctional services or sheltered living provided by a school or halfway house;
2. A long-term residential mental health program that lasts longer than 45 days;
3. Psychoanalysis or psychotherapy received as part of an educational training program, regardless of diagnosis or symptoms that may be present;
4. A court-ordered sex offender treatment program; or
5. A court ordered screening interview or treatment program under ORS 813.021.

Notwithstanding item 1 above, an Insured may receive covered outpatient services while living temporarily in a sheltered living situation.

A provider is eligible for reimbursement under this section if:

1. The provider is approved by the Department of Human Services;
2. The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or Accreditation of Rehabilitation Facilities;
3. The Insured is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or
4. The provider is providing Covered Medical Expenses under the policy.

Payments may not be made for support groups.

Outpatient coverage may include follow-up in-home service or outpatient services. In-home services may be limited to Insureds who are homebound and under the care of a Physician.

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

#### ***Benefits for Prescription Contraceptives and Services***

If the policy provides benefits for Prescription Drugs:

1. benefits will be provided under the Prescription Drug benefit for prescription Contraceptives; and
2. benefits will be provided on the same basis as any other Sickness for outpatient consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription Contraceptive.

"Contraceptive" means a drug or device approved by the United States Food and Drug Administration to prevent pregnancy.

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

#### ***Benefits for Prescription Drugs Dispensed at a Rural Health Clinic***

If the policy provides benefits for Prescription Drugs, benefits will be provided for prescription drugs dispensed by a licensed Physician at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed outside of the normal business hours of any pharmacy within 15 minutes of the clinic.

"Urgent medical condition" means a medical condition that arises suddenly, is not life-threatening, and requires prompt treatment to avoid the development of more serious medical problems.

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

### **Definitions**

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

**COPAY/COPAYMENT** means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

**COVERED MEDICAL EXPENSES** means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

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

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

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

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

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

**MEDICAL EMERGENCY** means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

As used in connection with this section, Emergency medical screening exam is the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition. Emergency services are those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of a patient.

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** 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.

**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 according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

- 1) Deductibles.
- 2) Copays.
- 3) Expenses that are not Covered Medical Expenses.

**PRE-EXISTING CONDITION** means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy. Insureds with documentation of prior creditable health coverage are eligible for prior credit towards the pre-existing condition exclusionary period. Coverage will be considered continuous from one school year to the next. The Insured is permitted to have one term or semester break without restarting the Pre-existing period. Conditions developed during a qualified break are not considered a Pre-existing Condition.

**SICKNESS** means sickness or disease of the Insured Person which causes loss, and originates 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.

**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. valued at the 80th percentile to determine 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. Nicotine addiction, except as specifically provided in the policy;
3. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the policy;
4. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
5. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
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;
8. Elective Surgery or Elective Treatment;
9. Elective abortion;
10. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
11. Flat foot conditions; supportive devices for the foot; fallen arches; and routine foot care including the care, cutting and removal of corns, calluses, toenails;
12. Health spa or similar facilities; strengthening programs;
13. Hearing examinations; hearing aids; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

14. Hirsutism; alopecia;
15. Hypnosis;
16. 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;
17. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
18. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
19. Investigational services;
20. Lipectomy;
21. Motor vehicle Injury;
22. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
23. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. Insureds with documentation of prior creditable health coverage are eligible for prior credit towards the Pre-existing Condition exclusionary period. Coverage will be considered continuous from one school year to the next. The Insured is permitted to have one term or semester break without restarting the Pre-existing period. Conditions developed during a qualified break are not considered Pre-existing Conditions. This exclusion will not be applied to an Insured Person who is under age 19;
24. Prescription Drugs, services or supplies as follows:
  - a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
  - b. Immunization agents, except as specifically provided in the policy, biological sera;
  - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs; except for prescribed drugs for a particular Sickness (such as cancer) that have not been approved by the United States Food and Drug Administration when the Health Resources Commission has determined that the drug is recognized as effective for the treatment of that Sickness in publications that the Commission determines to be equivalent to: The American Hospital Formulary Services drug information, "Drug Facts and Comparisons", The United States Pharmacopoeia drug information, or other publications that have been identified by the United States Secretary of Health and Human Services as authoritative; in the majority of relevant peer-reviewed medical literature; or by the United States Secretary of Health and Human Services;
  - d. Products used for cosmetic purposes;
  - e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
  - f. Anorectics - drugs used for the purpose of weight control;
  - g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
  - h. Growth hormones; or
  - i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

25. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
26. 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;
27. Routine Newborn Infant Care, well-baby nursery and related Physician charges; except as specifically provided in the policy;
28. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
29. Services provided normally without charge by the Health Service of the Policyholder; or 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 purulent sinusitis;
31. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
32. Speech therapy; naturopathic services;
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); and
37. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

### **Collegiate Assistance Program**

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

### **FrontierMEDEX: Global Emergency Medical Assistance**

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International Students: You are eligible to receive FrontierMEDEX services worldwide, except in your home country.

Domestic Students: You are eligible for FrontierMEDEX services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

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

**Key Services include:**

- \*Monitoring of Treatment
- \*Transfer of Medical Records
- \*Dispatch of Doctors/Specialists
- \*Transportation After Stabilization
- \*Hotel Arrangements for Convalescence
- \*Emergency Travel Arrangements
- \*Transfer of Funds
- \*Translation Services
- \*Transfer of Insurance Information to Medical Providers
- \*Continuous Updates to Family, Employer, and Home Physician
- \*Transportation to Join a Hospitalized Participant
- \*Replacement of Lost or Stolen Travel Documents
- \*Replacement of Corrective Lenses and Medical Devices
- \*Facilitation of Hospital Payments
- \*Medication, Vaccine and Blood Transfers
- \*Emergency Medical Evacuation
- \*Worldwide Medical and Dental Referrals
- \*Return of Dependent Children
- \*Repatriation of Mortal Remains
- \*Legal Referrals
- \*Message Transmittals

Please visit your school's insurance coverage page at [www.uhcsr.com](http://www.uhcsr.com) for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

- (800) 527-0218 Toll-free within the United States
- (410) 453-6330 Collect outside the United States

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

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

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

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

## **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 **Student**Resources, 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 **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

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

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

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

#### **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 if 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 **Student**Resources  
PO Box 809025  
Dallas, TX 75380-9025  
888-315-0447

### 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:

Oregon Insurance Division  
Consumer Advocacy Unit  
P. O. Box 14480  
Salem, OR 97309-0405  
(888) 877-4894  
(503) 947-7984  
Website: <http://www.insurance.oregon.gov/consumer/consumer.html>  
Email: [cp.ins@state.or.us](mailto:cp.ins@state.or.us)

### Online Access to Account Information

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UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to **My Account** at [www.uhcsr.com/myaccount](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 **Student**Resources' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

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

## **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.

## **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. ID Cards may also be accessed via our mobile site at my.uhcsr.com.

## **Claim Procedure**

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In the event of Injury or Sickness, students should:

- 1) Report to the Student Health Service 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, social security number and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
- 3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.



**The Plan is Underwritten by**

UnitedHealthcare Insurance Company

**Submit all Claims or Inquiries to:**

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-800-767-0700

customerservice@uhcsr.com

claims@uhcsr.com

**Sales/Marketing Services:**

UnitedHealthcare **Student**Resources

805 Executive Center Drive West, Suite 220

St. Petersburg, FL 33702

727-563-3400

1-800-237-0903

E-Mail: info@uhcsr.com

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

This Brochure is based on Policy # 2013-441-1

