



# 2009-2010 STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students at

**University of Washington**  
**Bothell Campus**



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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 detailed copy of our privacy practices by calling us toll-free at 1-800-973-4698 or visiting us at [www.uhcsr.com](http://www.uhcsr.com).

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## Eligibility

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All formally admitted matriculated students at the University of Washington - Bothell are eligible to enroll in this insurance Plan. International students are required to have and maintain insurance coverage and must purchase this plan, unless the student has other coverage. Students must remain enrolled in classes for the first 7 calendar days of instruction during the quarter in which you enroll for coverage.

The following students are not eligible to enroll in this Plan: Access Program, Certificate programs, Training workshops, Distance Learning, English as a Second Language, Noncredit classes, Conferences or Institutes, TA/RA/SA Appointees or UW and other state employees attending classes under the Employee Tuition Exemption Program.

Students must actively attend classes for at least the first 7 days after the date for which coverage is purchased. Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who enroll may also insure their Dependents. Eligible Dependents are the spouse or Domestic Partner and unmarried children under 25 years of age. Dependent Eligibility expires concurrently with that of the Insured student. See the Definitions section of the Brochure for the specific requirements needed to meet Domestic Partner eligibility.

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## How to Enroll

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Students must enroll online at [www.uhcsr.com](http://www.uhcsr.com). Eligible students who do enroll may also insure their spouse or registered domestic partner and/or children. Dependent coverage must be purchased at the same time as student coverage.

### **Newborn Infants**

Any child born of an Insured while that person is insured under this policy will be covered under the policy for the first 21 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 21 days. To continue the coverage the Insured must, within the 60 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 21 days after the child's birth.

### **Newly Acquired Dependents**

You may add newly acquired Dependents during the quarter by mail by completing a Dependent enrollment form found at [www.uhcsr.com](http://www.uhcsr.com). You will be required to pay the full premium for the quarter during which your newly acquired Dependent is enrolled (e.g., date of marriage or birth, or placement for adoption).

*Note: You must enroll your newly acquired Dependent within 30 days of marriage or domestic partner registration or 60 days of birth or placement for adoption in order to enroll them off quarter.*

## **Effective and Termination Dates**

The Master Policy becomes effective September 28, 2009. 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 September 26, 2010. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

If paying premium by sessions coverage expires as follows:

### **Premium Periods:**

Annual:	09/28/09 - 09/26/10	Autumn Quarter:	09/28/09 - 01/03/10
Winter/Spring/Summer:	01/04/10 - 09/26/10	Winter Quarter:	01/04/10 - 03/28/10
Spring/Summer:	03/29/10 - 09/26/10	Spring Quarter:	03/29/10 - 06/20/10
Summer:	06/21/10 - 09/26/10	Summer Quarter:	06/21/10 - 09/26/10

### **Premium Rates:**

	Annual	Winter/Spring/Summer	Spring/Summer	Summer	Quarterly
Student	\$1,667.96	\$1,250.97	\$833.98	\$416.99	\$416.99
Spouse	\$3,738.70	\$2,804.04	\$1,869.36	\$934.68	\$934.68
Each Child	\$2,501.94	\$1,876.47	\$1,250.98	\$625.49	\$625.49

The individual student's coverage becomes effective on the first day of the quarter for which premium has been paid. Premium payments must be received within 7 days of the beginning of the quarter. No enrollments after the first 7 days will be allowed except in the case of a Newly Acquired Dependent as described above. The individual student's coverage terminates on the last day of the policy year or the end of the period for 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 7 days after the coverage expiration date. It is the student's responsibility to make timely renewal 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 Policy.

## **Extension of Benefits After Termination**

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury will continue to be paid as long as the condition continues but not to exceed 365 days for Injury 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 After Termination" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

## Schedule of Medical Expense Benefits

**Up To \$200,000 Maximum Benefit Paid as Specified Below (For Each Injury or Sickness)  
\$300 Deductible (Per Insured Person) (Per Policy Year)**

*Maximum Deductible of \$75 per quarter*

The Policy provides benefits for the Usual and Customary Charges incurred, by an Insured Person, for loss due to a covered Injury or Sickness up to the Maximum Benefit of \$200,000 for each Injury or Sickness.

All copay/Deductibles specified below are in addition to the Policy Deductible.

The Preferred Provider for this plan is BeechStreet. 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 Expenses are 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.

There is an out-of-pocket limit per Insured of \$2,500 for Preferred Providers and \$5,000 for Out-of-Network Providers. The out-of-pocket maximum is met by accumulated coinsurance and does not include the Deductibles or any copayment under the plan. Additionally, the following items do not count towards the out-of-pocket maximums: 1) Penalties, balances remaining after maximums have been met and amounts above the Usual and Customary Charges; and 2) Covered Medical Expenses for outpatient rehabilitation, and neurodevelopmental therapy.

The following Wellness Health benefits are included: 1) One routine pap and pelvic examination Per Policy Year; 2) Routine testing and Labs for sexually transmitted diseases (Chlamydia, Gonorrhea, Herpes and HIV/AIDS); 3) Routine cholesterol testing; and 4) Immunization for Hepatitis A and B. Benefits 2) and 3) above are limited to a combined maximum of two tests Per Policy Year.

Benefits for "Women's Health Care Services" include but are not limited to: Maternity care, reproductive health services, gynecological care, general examinations and preventative care as medically appropriate and appropriate follow-up visits for these services.

**Policy Exceptions:** Benefits will be provided for blood-borne pathogen protocol services.

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

Preferred Allowance=PA	U&C=Usual and Customary	max=maximum
<b>INPATIENT</b>	<b>Preferred Provider</b>	<b>Out of Network</b>
<b>Hospital Expense</b> , daily semi-private room rate; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses 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.	\$300 copay per admission/80% of PA	\$400 Deductible per admission/60% of U&C
<b>Intensive Care/Hospital Expense</b>	\$300 copay per admission/80% of PA	\$400 Deductible per admission/60% of U&C
<b>Routine Newborn Care</b> , while Hospital Confined; and routine nursery care provided immediately after birth.	80% of PA	60% of U&C
<b>Hospice Care</b>	See Benefits for Home Health Care and Hospice Care on page 8	
<b>Physiotherapy</b>	80% of PA	60% of U&C

<b>INPATIENT</b>	<b>Preferred Provider</b>	<b>Out of Network</b>
<b>Surgeon's Fees</b> , in accordance with data provided by Ingenix. Includes coverage for multiple surgical procedures.	80% of PA	60% of U&C
<b>Assistant Surgeon</b>	80% of PA	60% of U&C
<b>Anesthetist</b> , professional services 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> , benefits are limited to one visit per day and 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
<b>Psychotherapy</b> , benefits are limited to one visit per day. Psychiatric Hospitals are not covered. <i>(See Benefits for Mental Disorders, page 11.) (20 days max per Policy Year.)</i>	\$300 copay per admission/80% of PA	\$400 Deductible per admission/60% of U&C
<b>OUTPATIENT</b>		
<b>Surgeon's Fees</b> , in accordance with data provided by Ingenix. Includes coverage for multiple surgical procedures.	80% of PA	60% of U&C
<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 for Physician's Visits are limited to one visit per day and do not apply when related to surgery or Physiotherapy.	80% of PA	60% of U&C
<b>Physiotherapy</b> , benefits are limited to one visit per day. <i>(Physician referral required; Medical Necessity will be required after 12 visits.)</i>	80% of PA	60% of U&C

OUTPATIENT	Preferred Provider	Out of Network
<b>Medical Emergency Expenses</b> , use of the emergency room and supplies. <i>(The copay/Deductible will be waived if admitted.)</i>	80% of PA / \$25 copay per visit	80% of U&C / \$25 Deductible per visit <i>(60% of U&amp;C for non-Medical Emergency treatment at an emergency room. \$25 Deductible per visit.)</i>
<b>Diagnostic X-Ray and Laboratory Services</b> , <i>(Including one pap smear Per Policy Year.)</i>	80% of PA	60% of U&C
<b>Radiation Therapy and Chemotherapy</b>	80% of PA	60% of U&C
<b>Tests and Procedures</b> , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-Rays and Lab Procedures.	80% of PA	60% of U&C
<b>Injections</b> , when administered in the Physician's office and charged on the Physician's statement. <i>(Benefits are payable for Hepatitis A and Hepatitis B injections only.)</i>	80% of PA	60% of U&C
<b>Prescription Drugs</b> , <i>UnitedHealthcare Network Pharmacy. Up to a 31-day supply per prescription. (Max copay/coinsurance of up to \$200 per prescription.)</i>	Tier 1 - \$10 copay per prescription / Tier 2 - 25% coinsurance per prescription / Tier 3 - 40% coinsurance per prescription	No Benefits
<b>Psychotherapy</b> , Benefits are limited to one visit per day. <i>(See Benefits for Mental Disorders, page 11.) (15 visits max Per Policy Year)</i>	<b>For Students:</b> First 3 visits are covered at 100%. Additional visits covered at 80%. <b>For Dependents:</b> 80% of U&C, 15 visits max Per Policy Year.	<b>For Students:</b> 60% of U&C, 5 visits max Per Policy Year. <b>For Dependents:</b> 60% of U&C, 15 visits max Per Policy Year.
OTHER		
<b>Ambulance Services</b>	60% of U&C	60% of U&C
<b>Durable Medical Equipment</b> , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	60% of U&C	60% of U&C
<b>Consultant Physician Fees</b> , when requested and approved by the attending Physician.	80% of PA	60% of U&C
<b>Dental Treatment</b>	See Dental Benefits on page 9	
<b>Alcoholism / Chemical Dependency</b> , <i>(\$14,500 max benefit in any consecutive 24 month period.)</i>	100% of PA/\$300 copay per inpatient admission	100% of U&C/\$400 Deductible per inpatient admission
<b>Maternity</b> , <i>(Includes the benefits of a midwife payable at 80% of Usual and Customary Charges.)</i>	Paid as any other Sickness/Includes prenatal testing	Paid as any other Sickness/Includes prenatal testing
<b>Routine Well-Child Care</b> , <i>(Benefits payable up to age 5 not to exceed \$5,000 max Per Policy Year.)</i>	Paid as any other Sickness	Paid as any other Sickness

<b>OTHER</b>	<b>Preferred Provider</b>	<b>Out of Network</b>
<b>Elective Abortion</b>	80% of PA	80% of U&C
<b>Complications of Pregnancy</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Mammography</b>	See Benefits for Mammography, Page 10	
<b>Home Health Services</b> , <i>(Including skilled nursing, physical, occupational, speech and/or respiratory therapy, and the services of a home health aide; appropriate medical equipment and supplies.)</i>	See Benefits for Home Health and Hospice Care, Page 8	
<b>Skilled Nursing Facility</b> , <i>(90 day max Per Policy Year.)</i>	\$300 copay per admission/80% of PA	\$400 Deductible per admission/60% of U&C
<b>Infusion Therapy</b> , <i>(\$25,000 max Per Policy Year in combination with Home Health and Hospice Expense Benefits.)</i>	80% of PA	60% of U&C
<b>Neurodevelopmental Therapy Services</b> , <i>(\$1,000 max Per Policy Year for Dependent children age 6 and under.)</i>	80% of PA	60% of U&C
<b>Vision Benefit</b> , <i>Eye Exam, \$75 max Per Policy Year; Hardware (lenses, frames and contacts) \$50 max Per Policy Year. Vision benefits are not subject to the Policy Quarterly Deductible.)</i>	100% of U&C	100% of U&C

### **UnitedHealthcare Network Pharmacy Benefits**

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits (up to 31 days) and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are a few 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/coinsurances. Your copayment/coinsurance is determined by the tier to which the Prescription Drug 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 877-417-7345 for the most up-to-date tier status.

\$10 copay per prescription order or refill for a Tier 1 Prescription Drug

25% coinsurance per prescription order or refill for a Tier 2 Prescription Drug

40% coinsurance per prescription order or refill for a Tier 3 Prescription Drug

Your maximum out of pocket is \$200 per prescription.

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

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about network pharmacies, please visit [www.uhcsr.com](http://www.uhcsr.com) and log in to your online account or call 877-417-7345.

## **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:

BeechStreet

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 1-800-973-4698 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 Hospital Expenses**

**PREFERRED HOSPITALS** - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call (800) 973-4698 for information about Preferred Hospitals.

**OUT-OF-NETWORK HOSPITALS** - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital 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 BeechStreet 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 routine, preventative or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered, if all other policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/AFP Screening; and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-973-4698.

## **Excess Provision**

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No benefit of this policy is payable for any expense incurred for Injury or Sickness which is paid or payable by Other Valid and Collectible Insurance.

This Excess Provision will not be applied to the first \$500 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

Other Valid and Collectible Insurance includes:

- 1) Group, individual or blanket insurance contracts and subscriber contracts; and
- 2) Group and individual coverage through closed panel plans.

Other Valid and Collectible Insurance does not include:

- 1) Hospital indemnity coverage benefits or other fixed indemnity coverage;
- 2) Accident only coverage;
- 3) Specified disease or specified accident coverage;
- 4) Limited benefit health coverage;
- 5) School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
- 6) Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- 7) Medicare supplement policies;
- 8) A state plan under Medicaid;
- 9) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;
- 10) Automobile insurance policies required by statute to provide medical benefits; or
- 11) Benefits provide as part of a direct agreement with a direct patient-provider primary care practice as defined by state law (section 3, chapter 267, Laws of 2007).

## **Benefits for Home Health Care and Hospice Care**

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Benefits shall be provided on the same basis as any other Sickness or Injury for home health care and hospice care for Insureds who are homebound and would otherwise require hospitalization. Benefits shall consist of services rendered by home health and hospice agencies licensed by the department of social and health services when recommended by a Physician.

Hospice care coverage shall provide benefits for terminally ill patients for an initial period of care of not more than six months. Limited extensions will be granted if the Insured Person is facing imminent death or is entering remission if certified in writing by the attending Physician.

Home health care coverage shall provide benefits for a maximum of one hundred thirty (130) health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one visit.

Benefits shall be subject to all Deductible, coinsurance, limitations and any provisions of the Policy.

## Dental Benefits

Subject to a \$25 Per Policy Year Per Insured Person / \$75 Per Policy Year per family Deductible, benefits will be paid for the following specific procedures. Payment will not exceed 100% of Usual and Customary Charges subject to a \$300 annual maximum.

Dental X-rays	Once every three year period for complete series (4 bitewing x-rays and up to 10 periapical x-rays) or panoramic x-rays. Supplementary bitewing x-rays are covered once every 6 month period.
Oral Routine Examinations	Two exams Per Policy Year
Oral Hygiene Instruction	Three sessions per lifetime
Fissure Sealants for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface	Once every three year period per tooth for dependent children through age 13.
Prophylaxis (cleaning, scaling and polishing)	Two treatments Per Policy Year.
Space maintainers when used to maintain space for eruption of permanent teeth	For children under age 12 only.
Topical application of fluoride	Two treatments Per Policy Year, through age 18.

Not included in the above benefits are:

- Diagnostic services and x-rays related to temporomandibular joints (jaw joints)
- Consultations
- Study models
- Caries susceptibility tests
- Plaque control program
- Oral hygiene instruction (except as listed above), dietary instruction and home fluoride kits
- Cleaning of a prosthetic appliance
- Replacement of a space maintainer previously paid for by the Company
- All other services not specifically included in the endorsement as covered dental benefits
- Behavior management
- Charges by any person other than a licensed dentist or licensed denturist, except for a licensed hygienist
- Charges for any services in excess of the percentages and maximums listed in the Schedule of Benefits
- Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements
- Charges that would not have been made or that the Insured Person would have had no obligation to pay in the absence of this Policy
- Local anesthesia, sterilization and supplies billed as separate charges (these services and items are included in allowance for procedure)
- Materials not approved by the American Dental Association
- Prescription Drugs, medications or supplies
- Services for Temporomandibular Joint Disorder
- Services to the extent that they are not recommended and approved by the licensed Dentist attending the Insured Person, charges above the Usual and Customary Charges as determined by the Company; charges for failure to keep scheduled appointments or filling our claim forms
- Study and diagnostic models.

For Injury to Sound, Natural Teeth: Subject to a \$100 per Injury Per Insured Person Deductible, benefits will be paid for 70% of Usual and Customary Charges. Payment will not exceed \$1,500 maximum for each Injury.

## **Mandated Benefits**

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### ***Benefits for Reconstructive Breast Surgery***

Benefits will be paid for reconstructive breast surgery (including prosthesis) resulting from a mastectomy which resulted from disease, illness, or Injury; regardless of when the mastectomy or the condition which made the mastectomy necessary was covered by this policy. Benefits will be paid for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size to the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. Benefits for Reconstructive Breast Surgery shall be commensurate with the Hospital and surgical benefits otherwise provided by this policy.

Benefits shall be limited by any maximum amounts specified in the Schedule of Benefits, any Deductible, copayment, coinsurance, limitations or other provisions of the policy.

### ***Benefits for Diabetes***

Benefits will be paid the same as any other Sickness for the following services and supplies for persons with diabetes:

- (1) Medically Necessary equipment and supplies, as prescribed by a Physician, including but not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and
- (2) Outpatient self-management training and education, including medical nutrition therapy, as ordered by the Physician. Diabetes outpatient self-management training and education must be provided by Physicians with expertise in diabetes.

Benefits shall be subject to all Deductibles, copayment, coinsurance, limitations or any other provisions of the Policy.

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

Benefits will be paid on the same basis as any other Sickness for screening or diagnostic mammography when recommended by a Physician, advanced registered nurse practitioner, or physician assistant.

Benefits shall be subject to all Deductibles, coinsurance, benefit maximums, limitations and all other provisions of the Policy.

### ***Benefits for Phenylketonuria Treatment***

Benefits will be paid the same as any other Sickness for the mineral and vitamin-enriched formulas necessary for the treatment of phenylketonuria.

Benefits shall be subject to all Deductibles, coinsurance, benefit maximums, limitations and all other provisions of the Policy.

### ***Benefits for Alcoholism/Chemical Dependency***

Benefits will be paid the same as any other Sickness for the treatment of Alcoholism/Chemical Dependency not to exceed \$14,500 in any consecutive twenty-four month period.

Benefits will include medically necessary treatment and supporting services provided by a state approved treatment program in an approved treatment facility.

Medically necessary detoxification must also be covered as a Medical Emergency as long as the Insured is not yet enrolled in a chemical dependency treatment program. Detoxification benefits are in addition to the Alcoholism/Chemical Dependency benefits.

Any Alcoholism/Chemical Dependency benefits received by an Insured during the twenty-four month consecutive period under this policy or under any prior policy with this company will be charged against the twenty-four month benefit period.

Alcoholism/Chemical Dependency means a Sickness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her societal or economic function is substantially disrupted.

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

### ***Benefits for Mental Disorders***

Benefits will be paid as specified in the Psychotherapy Benefit on the Schedule of Benefits for Mental Health Services for the treatment of Mental Disorders.

Mental health services means medically necessary inpatient and outpatient services provided to treat Mental Disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, with the exception of the following categories, codes and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "v" codes, and diagnostic codes 302 through 302.9 as found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 4th edition, published by the American Psychiatric Association; and (c) skilled nursing facility services, home health care, residential treatment, and custodial care.

If the policy provides benefits for Prescription Drugs, benefits will be paid for Prescription Drugs to treat Mental Disorders the same as and under the same terms and conditions as other Prescription Drugs under the policy.

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

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

Benefits will be paid the same as any other Sickness for prostate cancer screening when recommended by a Physician.

Benefits shall be subject to all Deductibles, copayment, coinsurance, benefit maximums, limitations, or any other provisions of the policy.

## **Definitions**

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**DOMESTIC PARTNER** means the partner of the Named Insured who:

- 1) has a close personal relationship with the Named Insured in lieu of a lawful marriage;
- 2) is not married to anyone.
- 3) is considered the Named Insured's "sole Domestic Partner";
- 4) is, along with the Named Insured, responsible for each other's common welfare;
- 5) is not related by blood to the Named Insured as close as would bar marriage.
- 6) is barred from a lawful marriage with the Named Insured. (This includes a partner of the same sex, or if one or both partners are transgender. However, this excludes opposite sex partners who are 62 years of age or older.)

**INJURY** means bodily injury which is: 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 one year after the date of accident; and 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.

**PRE-EXISTING CONDITION** means 1) the existence of symptoms within the 3 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which is diagnosed, treated or recommended for treatment within the 3 months immediately prior to the Insured's Effective Date under the policy.

**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.

**USUAL AND CUSTOMARY CHARGES** means 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. 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 loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Acupuncture - services, supplies and/or treatment;
2. Braces, appliances and Durable Medical Equipment, except as specifically provided in the Policy;
3. Bungee jumping; or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
4. 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;
5. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;
6. Dental treatment, except as specifically provided in the Schedule of Benefits;
7. Elective Surgery or Elective Treatment;
8. 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 disease process or except as specifically provided in the Policy.
9. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
10. Immunizations, services and supplies related to immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
12. Injury sustained while (a) participating in any intercollegiate 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;
13. Learning disabilities (excluding ADD/ADHD) and behavioral problems including services and supplies;
14. Marital and family counseling;
15. Naturopathic services;
16. Over-the-counter drugs and take home medications;
17. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

18. Pre-existing Conditions for a 3 month period, except for individuals who have been insured under another similar health plan for at least 3 months immediately prior to becoming insured under this Policy. Credit will be given for the period of time an Insured was covered under the immediately preceding health plan for periods less than the 3 month period. The pre-existing condition limitation may not apply in full or in part if the Insured had creditable coverage within the 62 days prior to their Effective Date under this policy. The Pre-existing Condition exclusion does not apply to: a) abortion; b) maternity, including complications, if such condition is covered under this policy; c) a covered Newborn Infant who, as of the last day of the 60-day period beginning with the date of birth, is covered under any immediately preceding health plan; d) a covered Adopted Child under the age of 18 who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption is covered under any immediately preceding health plan (except this shall not apply to coverage the adopted child may have had before such adoption or placement.)
19. Prescription Drugs, services or supplies as follows:
  - a) Products used for cosmetic purposes;
  - b) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
  - c) Drugs used to treat or cure baldness; anabolic steroids used for body building;
  - d) Anorectics - drugs used for the purpose of weight control;
  - e) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
  - f) Growth hormones; or
  - g) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
20. Prosthetic appliances and orthotic devices, except as specifically provided in the Policy;
21. 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; Examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; premarital examinations; impotence, organic or otherwise; reversal of sterilization procedures;
22. 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;
23. 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;
24. Sexual dysfunction – services, surgery or related expenses or supplies;
25. Sexual reassignment surgery – services, surgery or related expenses or supplies;
26. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
27. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery;
28. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
29. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
30. 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
31. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, surgery or treatment for obesity, surgery for removal of excess skin or fat.

## **Scholastic Emergency Services: Global Emergency Assistance Services**

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

International Students, insured spouse/Domestic Partner and insured minor child(ren): You are eligible to receive SES services worldwide, except in your home country.

Domestic Students, insured spouse/Domestic Partner and insured minor child(ren): You are eligible for SES 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.

SES services include Emergency Medical Evacuation and Return of Mortal Remains that meet the U.S. 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 SES services must be arranged and provided by SES, any services not arranged by SES will not be considered for payment.

Key Services include:

- Medical Consultation, Evaluation and Referrals
- Foreign Hospital Admission Guarantee
- Emergency Medical Evacuation
- Critical Care Monitoring
- Medically Supervised Repatriation
- Prescription Assistance
- Transportation to Join Patient
- Care for Minor Children Left Unattended Due to a Medical Incident
- Return of Mortal Remains
- Emergency Counseling Services
- Lost Luggage or Document Assistance
- Interpreter and Legal Referrals

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

To access services please call:

(877) 488-9833 Toll-free within the United States

(609) 452-8570 Collect outside the United States

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

When calling the SES 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 Reference Number
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
6. Information of where the physician can be immediately reached

Scholastic Emergency Services 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 SES. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure for Program Guidelines as well as limitations and exclusions pertaining to the SES program.

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## Claims Appeal

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Insureds with questions or complaints may call the Customer Service Department at 1-800-973-4698. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Company, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

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## Subrogation and Recovery Rights

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**Right to Subrogation:** The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for Benefits made by the Company to or for benefits of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company. The Company shall recover only that portion paid by the Company which is in excess of the amount necessary to fully compensate the Insured for all expenses incurred as a result of his/her loss. The Insured shall be permitted to recoup his/her general damages which is not limited to medical expenses, from the tort-feasor before subrogation provided that in so doing, the Insured does not prejudice the rights of the Company.

**Right of Recovery:** Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

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## Claim Procedure

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In the event of Injury or Sickness, students should:

- 1) Report to their Physician or Hospital.
- 2) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, 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 90 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 STUDENTRESOURCES**

P.O. Box 809025  
DALLAS, TEXAS 75380-9025  
800-973-4698  
customerservice@uhcsr.com  
claims@uhcsr.com

***Sales/Marketing Service:***

**UNITEDHEALTHCARE STUDENTRESOURCES**

805 EXECUTIVE CENTER DRIVE WEST, SUITE 220  
ST. PETERSBURG, FL 33702  
800-237-0903

**E-mail (Inquiries only):**

[info@uhcsr.com](mailto:info@uhcsr.com)

**ONLINE SERVICES:** Please visit our Website at [www.uhcsr.com](http://www.uhcsr.com) for Online Enrollment, Brochures, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services.

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 #2009-201517-1**

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