

2012-2013

Student Injury and Sickness Insurance Plan

Designed especially for:

International Student/Scholar Care Plan Plus

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



Eligibility

All regular, full time and part time eligible students, scholars or other persons with a current passport who: 1) are engaged in international educational activities; and 2) are temporarily located outside his/her home country as a non resident alien; and 3) have not obtained permanent residency status are eligible to enroll in this Plan on a voluntary basis. Those enrolled in an Optional Practical Training program (with a F-1 or J-1 visa) who were previously enrolled in this Plan are eligible. Eligible Dependents of insured student may enroll concurrently on a voluntary basis.

The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased, with the exception of those with a J Visa or those in an Optional Practical Training program.

Accident coverage for Intercollegiate Sports injuries is provided under a separate policy issued to ACSA International Student/Scholar Care Plus Plan, 2012-202374-92. This Intercollegiate sports plan provides coverage for ACSA International Student/Scholar Care Plus Plan's Intercollegiate sports related injuries up to a maximum benefit of \$5,000 per Injury and club sports up to a maximum benefit of \$2,500 for each Injury.

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PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured 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 Named Insured 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 and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured (as defined) shall be determined in accordance with the following:

- 1) If a Named Insured has Dependents on the date he or she is eligible for insurance; or
- 2) If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
 - (a) On the date the Named Insured marries the Dependent; or
 - (b) On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the "Definitions" section of this policy.

Dependent eligibility expires concurrently with that of the Named Insured.

Eligible persons may be insured under this policy subject to the following:

- 1) Payment of premium as set forth on the policy application; and,
- 2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

- 1) The Effective Date of the policy; or
- 2) The date premium is received by the Administrator.

Dependent coverage will not be effective prior to that of the Named Insured.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid; or
- 2) The date the policy terminates.

The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid;
- 2) The date the policy terminates; or
- 3) The date the Named Insured's coverage terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

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

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss.

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

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

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

SUBROGATION: 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 benefit 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.

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.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

PART III DEFINITIONS

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

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

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.

CREDITABLE COVERAGE means (1) Medicare or Medicaid; (2) an employer-based health insurance or benefit plan with similar benefits to this Policy (3) an individual policy; health maintenance organization; fraternal benefit society; nonprofit medical and surgical plan or hospital service plan that provides similar benefits to the basic plan pursuant to chapter 58-18B of the South Dakota Statutes, if the policy has been in effect for at least one year; or an employee benefit plan subject to ERISA; (4) Armed Forces Personnel Medical and Dental Care; (5) Indian Health Service or tribal organization medical care program; (6) a state health benefits risk pool; (7) Federal Employees Health Benefit Plan; (8) a public health plan; or (9) the Peace Corps Act health benefit plan; (10) a short-term limited-duration policy; or (11) a College Plan.

CUSTODIAL CARE means services that are any of the following:

- 1) Non-health related services, such as assistance in activities.
- 2) Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- 3) Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

DEPENDENT means the spouse (husband or wife) of the Named Insured and their dependent-children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

A dependent will be eligible to continue coverage after age 26 up to, but not exceeding the age of 29, if the dependent remains a full time student.

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

- 1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap.
- 2) Chiefly dependent upon the Insured Person for support and maintenance.

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

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

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

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis therapeutic services and major surgery either on the premises or in facilities under the supervision of Physician's on a prearranged basis; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental Illness or Substance Use Disorder.

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

INJURY means bodily injury which is all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEWBORN INFANT OR ADOPTED CHILD means any child born of an Insured or adopted by the Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Adopted children will be covered upon the earlier of: 1.) The date of placement for the purpose of adoption, or 2.) The date of entry of an order granting the adoptive parent custody of the child for the purpose of adoption. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year 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.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than the Insured Person or a member of the Insured Person's immediate family. This exclusion does not apply in those areas in which the immediate family member is the only Physician in the area and acting within the scope of their normal employment.

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

PHYSIOTHERAPY means any form of the following short-term rehabilitation therapies: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

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

PRE-EXISTING CONDITION means any condition which is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

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

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

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

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

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

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

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

PART IV
EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this 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.

PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
INTERNATIONAL STUDENT/SCHOLAR CARE PLUS PLAN - CARE PLAN PLUS
2012-202374-92
INJURY AND SICKNESS BENEFITS

Maximum Benefit	\$1,250,000 (Per Insured Person, Per Policy Year)
Deductible Preferred Providers	\$50 (Per Insured Person, Per Policy Year)
Deductible Out of Network	\$250 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Providers	90% except as noted below
Coinsurance Out of Network	70% except as noted below
Out-of-Pocket Maximum Preferred Providers	\$5,000 (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.

Preferred Provider 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. 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 if treatment is received at the Student Health Center.

All Out-of-Network Deductibles are in addition to the Policy Deductible unless stated otherwise.

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. 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

Inpatient	Preferred Provider	Out-of-Network Provider
Room & Board:	Preferred Allowance	Usual and Customary Charges
Intensive Care:	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous:	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care:	Paid as any other Sickness	Paid as any other Sickness
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
Surgery:	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing:	Preferred Allowance	Usual and Customary Charges
Outpatient	Preferred Provider	Out-of-Network Provider
Surgery:	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous:	Preferred Allowance	Usual and Customary Charges
<i>(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)</i>		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Physician's Visits:	Preferred Allowance \$20 Copay per visit	Usual and Customary Charges \$20 Deductible per visit
Physiotherapy: <i>(Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation.)</i>	Preferred Allowance	Usual and Customary Charges
Medical Emergency:	Preferred Allowance \$50 Copay per visit	90% of Usual and Customary Charges \$100 Deductible per visit <i>(Deductible per visit will be waived if admitted to the Hospital.)</i>
X-rays:	Preferred Allowance	Usual and Customary Charges
Radiation Therapy:	Preferred Allowance	Usual and Customary Charges
Laboratory:	Preferred Allowance	Usual and Customary Charges
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance \$10 Copay per visit	Usual and Customary Charges \$10 Deductible per visit
Chemotherapy:	Preferred Allowance	Usual and Customary Charges
Prescription Drugs:	80% of Usual and Customary Charges	80% of Usual and Customary Charges
Other	Preferred Provider	Out-of-Network Provider
Ambulance:	Preferred Allowance	Usual and Customary Charges
Durable Medical Equipment: <i>(\$1,000 maximum (Per Policy Year))</i>	Preferred Allowance	Usual and Customary Charges
<i>(Durable Medical Equipment benefits payable under the \$1,000 maximum per policy year are not included in the \$1,250,000 Maximum Benefit.)</i>		
Consultant:	Paid under Physician's Visits	Paid under Physician's Visits
Dental: <i>(\$100 maximum per tooth) (\$500 maximum (Per Policy Year))</i>	90% of Usual and Customary Charges	90% of Usual and Customary Charges
<i>(Benefits paid on Injury to Sound, Natural Teeth only. Benefits are not subject to the \$1,250,000 Maximum Benefit.)</i>		
Maternity: <i>(If an Insured is pregnant on the Termination Date, and the conception occurred while covered under this policy, Covered Medical Expenses for such pregnancy will continue to be paid through the term of the pregnancy.)</i>	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion: <i>(\$500 maximum (Per Policy Year))</i>	Paid as any other Sickness	Paid as any other Sickness
<i>(Elective Abortion benefits are not subject to the \$1,250,000 Maximum Benefit.)</i>		
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Repatriation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
Medical Evacuation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
AD&D:	\$3,750 - \$15,000 maximum	\$3,750 - \$15,000 maximum
CAT Scan/MRI:	Preferred Allowance \$100 Copay per visit	Usual and Customary Charges \$100 Deductible per visit
Injury due to Needle Stick: <i>(Injury due to needle stick, fluid exposures (needle-sticks, face splashes, etc.) experienced by students while engaging in school related activities in a clinic setting.)</i>	100% of Preferred Allowance	Usual and Customary Charges
Acupuncture: <i>(10 visits maximum) (Acupuncture benefits are not subject to the \$1,250,000 Maximum Benefit.)</i>	Preferred Allowance \$25 Copay per visit	Usual and Customary Charges \$25 Deductible per visit
Preventive Care Services:	100% of Preferred Allowance <i>(No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.)</i>	No Benefits
Diabetes Services: <i>(See Benefits for Diabetes)</i>	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider	Out-of-Network Provider
Mental Illness Treatment: <i>(See also Benefits for Biologically Based Mental Illness)</i>	Paid as any other Sickness	Paid as any other Sickness
Reconstructive Surgery Following Mastectomy: <i>(See Benefits for Breast Reconstruction)</i>	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment:	Paid as any other Sickness	Paid as any other Sickness
Urgent Care Center:	Preferred Allowance \$25 Copay per visit	Usual and Customary Charges \$25 Deductible per visit

SUPPLEMENTAL MEDICAL

Maximum Benefit No Benefits

CATASTROPHIC MEDICAL

Maximum Benefit No Benefits

SHC Referral Required: Yes () No (X)

Conversion Permitted: Yes () No (X)

() **52 Week Benefit Period** or (X) **Extension of Benefits**

***Pre Admission Notification:** Yes (X) No ()

Other Insurance: (X)***Excess Insurance** () **Primary Insurance**

*If benefit is designated, see endorsement attached.

PART VI
PREFERRED PROVIDER INFORMATION

“**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 1-800-505-4160 and/or by asking the provider when making an appointment for services.

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

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

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

Inpatient Expenses

PREFERRED PROVIDERS – Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-800-505-4160 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.

PART VII
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any Coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when confined as an Inpatient; and 2) general nursing care provided and charged by the Hospital.
2. **Intensive Care:** Payable under Room and Board Expense or as provided in the Schedule of Benefits.
3. **Hospital Miscellaneous Expenses:** 1) when confined as an Inpatient; or 2) as a precondition for being confined as an Inpatient. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; 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.
4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.
5. **Physiotherapy (Inpatient):** See Schedule of Benefits.
6. **Surgery:** Physician's fees for Inpatient surgery. 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.
7. **Assistant Surgeon Fees:** in connection with Inpatient surgery, if provided in the Schedule of Benefits.
8. **Anesthetist Services:** professional services administered in connection with Inpatient surgery.
9. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while an Inpatient; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
10. **Physician's Visits (Inpatient):** non-surgical services when confined as an Inpatient. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the Inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.
11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.
12. **Surgery (Outpatient):** Physician's fees for outpatient surgery. 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.

13. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.
14. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.
15. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.
16. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the Inpatient benefit for Physician's Visits, but not both on the same day. Physician's Visits for preventive care are provided as specified under Preventive Care Services.
17. **Physiotherapy (Outpatient):** benefits are limited to one visit per day. 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. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.
18. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.
19. **Diagnostic X-ray Services (Outpatient):** Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
20. **Radiation Therapy (Outpatient):** See Schedule of Benefits.
21. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
22. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures. The following therapies will be paid under the Tests and Procedures (Outpatient) benefit: inhalation therapy; infusion therapy; pulmonary therapy; and respiratory therapy. Tests and Procedures for preventive care are provided as specified under Preventive Care Services.
23. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.
24. **Chemotherapy (Outpatient):** See Schedule of Benefits.
25. **Prescription Drugs (Outpatient):** See Schedule of Benefits.
26. **Ambulance Services:** See Schedule of Benefits.
27. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. 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. If more than one prosthetic device can meet the Insured's functional need, benefits are available only for the prosthetic device that meets the minimum specifications for the Insured's needs. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

28. **Consultant Physician Fees:** when requested and approved by the attending Physician.
29. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.
30. **Mental Illness Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; and 2) on an outpatient basis including intensive outpatient treatment. Benefits are limited to one visit per day. See also Benefits for Biologically Based Mental Illness.
31. **Substance Use Disorder Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; 2) on an outpatient basis including intensive outpatient treatment. Benefits will be payable for inpatient treatment of alcoholism at any South Dakota approved inpatient alcoholism treatment facility. Benefits are limited to one visit per day.
32. **Maternity:** Same as any other Sickness. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.
33. **Complications of Pregnancy:** Same as any other Sickness.
34. **Preventive Care Services:** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
35. **Reconstructive Breast Surgery Following Mastectomy:** same as any other Sickness and in connection with a covered mastectomy. See Benefits for Breast Reconstruction.
36. **Diabetes Services:** same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes.
37. **Urgent Care Center:** benefits are limited to the facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.
38. **Repatriation:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under this policy.
39. **Medical Evacuation:** 1) when Hospital Confined for at least three - five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under this policy.
40. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

**PART VIII
MANDATED BENEFITS**

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Sickness for mammography screening as follows:

1. Ages thirty-five (35) to thirty-nine (39), one baseline mammogram;
2. Ages forty (40) to forty-nine (49), one mammogram every other year;
3. Age fifty (50) and older, one mammogram every year; or
4. More often if recommended by a Physician.

“Low-dose mammography” means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad midbreast, with two views for each breast and with interpretation by a qualified radiologist.

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

BENEFITS FOR BREAST RECONSTRUCTION

Benefits will be paid the same as any other Sickness for breast reconstruction recommended by a Physician following a covered mastectomy for:

1. 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 complication of all states of mastectomy, including lymphedemas.

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

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for equipment, supplies, and self-management training and education, including medical nutrition therapy, for treatment of Insureds diagnosed with diabetes if prescribed by a Physician. Medical nutrition therapy does not include any food items or nonprescription drugs.

The benefit for Medically Necessary equipment and supplies shall include blood glucose monitors, blood glucose monitors for the legally blind, test strips for glucose monitors, urine testing strips, insulin, injection aids, lancets, lancet devices, syringes, insulin pumps and all supplies for the pump, insulin infusion devices, prescribed oral agents for controlling blood sugars, glucose agents, glucagon kits, insulin measurement and administration aids for the visually impaired, and other medical devices for the treatment of diabetes.

Diabetes self-management training and education shall be covered if: (a) the service is provided by a Physician, nurse, dietitian, pharmacist, or other licensed health care provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified as a diabetes educator; and (b) the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the South Dakota Department of Health

The benefit for diabetes self-management training is limited to (a) persons who are newly diagnosed with diabetes or have received no prior diabetes education; (b) persons who require a change in current therapy; (c) persons who have a co-morbid condition such as heart disease or renal failure, or (d) persons whose diabetes condition is unstable. Under these circumstances, no more than two comprehensive education programs per lifetime and up to eight follow-up visits per year are covered. Coverage is limited to the closest available qualified education program that provides the necessary management training to accomplish the prescribed treatment.

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

BENEFITS FOR DRUG TREATMENT OF CANCER OR LIFE THREATENING CONDITIONS

When Prescription Drug benefits are payable under the policy, benefits will be provided for drugs for treatment of cancer or life threatening conditions although the drug has not been approved by the Food and Drug Administration for that indication if that drug is recognized for treatment of such indication in one of the standard reference compendia or in the appropriate medical literature. The prescribing Physician must submit documentation supporting the proposed off-label use or uses to the Company if requested. Coverage shall include Medically Necessary services associated with the administration of such drugs.

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

BENEFITS FOR BIOLOGICALLY BASED MENTAL ILLNESS

Benefits will be paid the same as any other Sickness for services and supplies for the Medically Necessary treatment of Biologically Based Mental Illness when recommended by a Physician.

Biologically Based Mental Illness means schizophrenia and other psychotic disorders, bipolar disorder, major depression and obsessive-compulsive disorder.

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

BENEFITS FOR DENTAL ANESTHESIA

Benefits shall be provided for dental anesthesia and related Hospital Covered Medical Expenses for services and supplies provided to a covered Insured Person who:

- (1) Is a child under age five; or
- (2) Is severely disabled or otherwise suffers from a developmental disability as determined by a Physician which places such child at serious risk.

Benefits shall be subject to all Deductible, 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. Subject to the following:

- (1) An annual medically recognized diagnostic examination, including a digital rectal examination and a prostate-specific antigen test, as follows:
 - (a) For asymptomatic men aged fifty and over; and
 - (b) For men aged forty-five and over at high risk for prostate cancer; and
 - (c) For males of any age who have a prior history of prostate cancer, medically indicated diagnostic testing at intervals recommended by a Physician, including the digital rectal examination, prostate-specific antigen test, and bone scan.

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

PART IX
EXCLUSIONS AND LIMITATIONS

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. Acne;
2. Addiction, such as: nicotine addiction, except as specifically provided in the policy; and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
3. Biofeedback;
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; removal of warts, non-malignant moles and lesions;
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 Teeth;
8. Elective Surgery or Elective Treatment;
9. 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;
10. Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery);
11. 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;
12. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
13. Injury sustained while (a) participating in any interscholastic, club, 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;
14. Organ transplants, including organ donation;
15. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation
16. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

17. Pre-existing Conditions for a period of 6 months, except for individuals who have been continuously insured under the student association's student insurance policy for at least 6 consecutive months. Credit will be given for the time the Insured was covered under previous Creditable Coverage if the Creditable Coverage was continuous to a date not more than sixty-three (63) days prior to the Insured's Effective Date under this Policy. This exclusion will not be applied to an Insured Person who is under age 19;
18. 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, blood or blood products administered on an outpatient basis;
 - c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs; except as specifically provided in the policy;
 - d) Products used for unapproved cosmetic indications;
 - 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.
19. 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;
20. 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;
21. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
22. 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;
23. Services provided normally without charge by the Health Service of a college or university; or services covered or provided by a student health fee;
24. 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;
25. 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;
26. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
27. Supplies, except as specifically provided in the policy;
28. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
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, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

EXCESS PROVISION

No benefit of this policy is payable for any expense incurred for Injury or Sickness which is paid or payable by: 1) other valid and collectible insurance; or, 2) under an automobile insurance policy.

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

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

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

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" (and under Major Medical, if coverage is afforded under Major Medical) provision.

For Loss Of:

Life	\$15,000
Two or More Members	\$15,000
One Member	\$ 7,500
Thumb or Index Finger	\$ 3,750

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.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

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.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

**RESOLUTION OF GRIEVANCE NOTICE
INTERNAL APPEAL PROCESS AND EXTERNAL INDEPENDENT REVIEW PROCESS
RELATED TO HEALTH CARE SERVICES**

DEFINITIONS

For the purpose of this Notice, the following terms are defined as shown below:

Adverse Determination means:

1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy as an Insured Person;
3. Any prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy; or
4. A rescission of coverage.

Authorized Representative means:

1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

Director means the Director of the Division of Insurance.

Evidenced – based Standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

Final Adverse Determination means an Adverse Determination involving a Covered Medical Expense that has been upheld by the Company, at the completion of the Company's internal appeal process or an Adverse Determination for which the internal appeals process has been deemed exhausted in accordance with this notice.

Prospective Review means Utilization Review performed: (1) prior to an admission or the provision of a health care service or course of treatment; and (2) in accordance with the Company's requirement that the service be approved, in whole or in part, prior to its provision.

Retrospective Review means any review of a request for a Covered Medical Expense that is not a Prospective Review request. Retrospective review does not include the review of a claim that is limited to the veracity of documentation or accuracy of coding.

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

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

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

INTERNAL APPEAL PROCESS

Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination

Upon receipt of the request for an Internal Review, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination.

Within 3 working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:

1. Any new or additional evidence considered by the Company in connection with the grievance;
2. Any new or additional rationale upon which the decision was based.

The Insured Person or Authorized Representative shall have 10 calendar days to respond to any new or additional evidence or rationale.

The company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative as follows:

1. For a Prospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 60 days after the Company's receipt of the grievance.

Time periods shall be calculated based on the date the Company receives the request for the Internal Review, without regard to whether all of the information necessary to make the determination accompanies the request.

The written notice of Final Adverse Determination for the Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
 - a. the date of service;
 - b. the name health care provider; and
 - c. the claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
 - a. the specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
 - b. reference to the specific Policy provisions upon which the determination is based;
 - c. a statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
 - d. if applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
 - e. if the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
 - f. instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;

5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation; and
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction.
7. Notice of the Insured Person's right to contact the Director's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review (EIR) of an Adverse Determination

The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:

1. involving Urgent Care Requests; and
2. related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received emergency services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Authorized Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Insured Person has been notified of the final determination.

At the same time an Insured Person or an Authorized Representative files an EIR request, the Insured Person or the Authorized Representative may file:

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to gain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

The notice of Final Adverse Determination may be provided orally, in writing, or electronically.

EXTERNAL INDEPENDENT REVIEW

An Insured Person or Authorized Representative may submit a request for an External Independent Review when the service in question:

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

A request for an External Independent Review shall not be made until the Insured Person or Authorized Representative has exhausted the Internal Appeals process. The Internal Appeal Procedure shall be considered exhausted if:

1. The Company has issued a Final Adverse Determination as detailed herein;
2. The Insured Person or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the Company within 30 days and the Insured Person or Authorized Representative has not requested or agreed to a delay;
3. The Company fails to strictly adhere to the Internal Appeal process detailed herein; or
4. The Company agrees to waive the exhaustion requirement.

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Director. Upon request of an External Review, the Director shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

I. Standard External Review (SER) Process

1. Within 5 business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
 - a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. the Insured Person has exhausted the Company's Internal Appeal Process;
 - c. the Insured Person has provided all the information and forms necessary to process the request; and
 - d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. Within 1 business day after completion of the preliminary review, the Company shall notify the Director, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
3. After receiving notice that a request is eligible for SER, the Director shall, within 1 business day:
 - a. Assign an Independent Review Organization (IRO) from the Director's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4.
 - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
 - b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
 - c. If the Company reverses its decision, the Company shall provide written notification within 1 business day to the Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Director, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

II. Expedited External Review (EER) Process

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Director at the time the Insured Person receives:
 - a. An Adverse Determination if:
 - (i) the Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
 - (ii) the Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

- b. A Final Adverse Determination, if:
 - (i) the Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - (ii) 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.

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.

2. Upon receipt of a request for an EER, the Director shall immediately review the request to determine that:
 - a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. the Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sections II. 1. a. and b. shown above;
 - c. the Insured Person has provided all the information and forms necessary to process the request; and
 - d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
3. Immediately after completion of the review, the Company shall notify the Director, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director
4. When a request is complete and eligible for an EER, the Director shall immediately assign an IRO from the Director's approved list and notify the Company of the name of the assigned IRO.
 - a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
 - b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
5.
 - a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
6. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
 - a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
 - b. Notify the Director, the Company, the Insured Person, and, if applicable, the Authorized Representative.
7. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

III. Standard Experimental or Investigational Treatment External Review (SEIER) Process

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Director.
2. Within 5 business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
 - a. the individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
 - b. the recommended or requested health care services or treatment:
 - (i) is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - (ii) is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. the Insured Person's treating Physician has certified that one of the following situations is applicable:
 - (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
 - (iii) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;

- d. the Insured Person's treating Physician:
 - (i) has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - (ii) who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. the Insured Person has exhausted the Company's Internal Appeal Process; and
 - f. the Insured Person has provided all the information and forms necessary to process the request.
3. Within 1 business day after completion of the preliminary review, the Company shall notify the Director, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
 - b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
 4. After receiving notice that a request is eligible for SEIER, the Director shall, within 1 business day:
 - a. Assign an IRO from the Director's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
 5. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SEIER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
 6. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
 7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
 - b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
 8. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational Treatment External Review (EEIER) Process

1. An Insured Person or an Authorized Representative may make an oral request for an Expedited Experimental or Investigational Treatment External Review (EEIER) with the Director at the time the Insured Person receives:
 - a. An Adverse Determination if:
 - (i) The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
 - (ii) The 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 promptly initiated; or
 - b. A Final Adverse Determination, if:
 - (i) The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - (ii) 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 promptly initiated.

An EEIER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.
2. Upon receipt of an EEIER request notice, the Company shall immediately complete a preliminary review to determine that:
 - a. the individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
 - b. the recommended or requested health care services or treatment:
 - (i) is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - (ii) is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. the Insured Person's treating Physician has certified that one of the following situations is applicable:
 - (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
 - (iii) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
 - d. the Insured Person's treating Physician:
 - (i) has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - (ii) who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. the Insured Person has exhausted the Company's Internal Appeal Process unless the Insured person is not required to do so as specified in Section IV. 1. a. and b. above; and
 - f. the Insured Person has provided all the information and forms necessary to process the request.
3. The Company shall immediately notify the Director, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for an EEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
4. After receiving notice that a request is eligible for EEIER, the Director shall immediately:
 - a. Assign an IRO from the Director's approved list; and
 - b. Notify the Company of the name of the assigned IRO.
5. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.

6. a. If the EEIER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EEIER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EEIER.
- b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EEIER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
7. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the EEIER.
- b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
8. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
9. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the EEIER.
 - b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
10. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 5 calendar days after being selected by the IRO.
11. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
 - a.
12. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

An External Review decision is binding on the Company except to the extent the Company has other remedies available under state law. An External Review decision is binding on the Insured Person except to the extent the Insured Person has other remedies available under applicable federal or state law. An Insured Person or an Authorized Representative may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Insured Person has already received an External Review decision.

Claim Procedure

In the event of Injury or Sickness, students should:

- 1) Report to the Student Health Service for treatment or 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, SD ID number and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
- 3) 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.

Submit all Claims or Inquiries to:
FirstStudent
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-505-4160
or visit our website at www.firststudent.com

The Plan is Underwritten By:
UnitedHealthcare Insurance Company

For Questions on Enrollment Contact:
Insurance for Students
5295 Town Center Road, Suite 101
Boca Raton, Florida 33486
1-800-356-1235
www.insuranceforstudents.com

Online Access to Account Information

UnitedHealthcare StudentResources Insureds have online access to claims status, EOBs, correspondence and coverage information via My Account at www.firststudent.com. Insureds can also print a temporary ID card, request a replacement ID card and locate network providers from My Account.

If you don't already have an online account, simply select the "Create an Account" link from the home page at www.firststudent.com. Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from www.firststudent.com to access your account information.

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

This Brochure is based on Policy # 2012-202374-92 v5