2012 - 2013

PLEASE NOTE:

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

Student Injury and Sickness Insurance Plan

Designed Especially for Students of

Savannah State University

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

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $100,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-866-403-8267. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a detailed copy of our privacy practices by calling us toll-free at 1-866-403-8267 or by visiting us at www.uhcsr.com/usg.

Eligibility

All students enrolled for six (6) or more credits per term or participating in OPT are eligible to enroll in this insurance Plan, excluding those students that are required to enroll in the plan as stated below.

The students required to enroll in the plan are as follows:

1. All undergraduate and ESL international students holding F or J visas.
2. All undergraduate students enrolled in programs that require proof of health insurance.
3. All graduate students receiving a full tuition waiver as part of their graduate assistantship award.
4. All graduate international students and visiting scholars holding F or J visas.
5. All graduate students enrolled in programs that require proof of health insurance.
6. All graduate students receiving fellowships that fully fund their tuition.

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

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

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy becomes effective at 12:01 a.m., August 1, 2012. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., July 31, 2013. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

Extension of Benefits after Termination

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

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

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

Pre-Admission Notification

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

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

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

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

Schedule of Medical Expense Benefits

Injury and Sickness

Maximum Benefit: $100,000 Paid as Specified Below (Per Insured Person) (Per Policy Year)

Deductible Preferred Provider: $300 (Per Insured Person) (Per Policy Year)

Deductible Preferred Provider: $750 (For all Insureds in a Family) (Per Policy Year)

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

Deductible Out-of-Network: $900 (For all Insureds in a Family) (Per Policy Year)

Coinsurance Preferred Provider: 80% except as noted below

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

Out-of-Pocket Maximum Preferred Providers: $4,500 (Per Insured Person, Per Policy Year)

Out-of-Pocket Maximum Preferred Providers: $15,000 (For all Insureds in a Family, Per Policy Year)

Out-of-Pocket Maximum Out of Network: $7,500 (Per Insured Person, Per Policy Year)

Out-of-Pocket Maximum Out of Network: $24,000 (For all Insureds in a Family, Per Policy Year)

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $100,000.

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.

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

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

UnitedHealthcare Pharmaceutical Solutions is the vendor the company contracts with to provide a network of pharmacies.

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

PA = Preferred Allowance	U&C = Usual & Customary Charges	
INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Hospital Expense, daily semi-private room rate when confined as an Inpatient; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of U&C
Intensive Care	80% of PA	60% of U&C
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth. *(See also Benefits for Postpartum Care)*	Paid as any other Sickness	
Physiotherapy	80% of PA	60% of U&C
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits are limited to one visit per day and do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of U&C
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
Physician's Visits, benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of PA / $20 Copay per visit	60% of U&C
Physiotherapy, 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. *(30 visits maximum Per Policy Year)*	80% of PA	60% of PA
Medical Emergency Expenses, 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.	80% of PA	80% of U&C
Diagnostic X-ray Services	80% of PA	60% of U&C
Radiation Therapy	80% of PA	60% of U&C
Chemotherapy	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Laboratory Services	80% of PA	60% of U&C
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-Rays and Lab Procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C
Prescription Drugs	UnitedHealthcare Network Pharmacy (UHPS) / $15 Copay per prescription for Tier 1 / $30 Copay per prescription for Tier 2 / $50 Copay per prescription for Tier 3 / up to a 31-day supply per prescription *(Mail order Prescription Drugs through UHPS at 2.5 times the retail Copay up to a 90 day supply.)* *(University Health Center Pharmacy: Copay waived for generic drugs / $5 Copay per prescription for brand name / $10 Copay per prescription for non-formulary drugs / up to a 31 day supply per prescription.)*	$15 Deductible per prescription for generic drugs / $30 Deductible per prescription for brand name / up to a 31-day supply per prescription

OTHER	Preferred Providers	Out-of-Network Providers
Ambulance Services	70% of PA *(If ambulance referral is initiated by Student Health Center, Deductible is waived.)*	70% of U&C
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.	80% of PA	60% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	80% of PA	60% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *(Benefits are not subject to the $100,000 Maximum Benefit.)*	80% of U&C	60% of U&C
Dental Treatment, benefits paid for the removal of impacted wisdom teeth only.	80% of PA	60% of U&C
Maternity, *(See also Benefits for Postpartum Care)*	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Mental Illness Treatment, services received on an Inpatient and outpatient basis. Benefits are limited to one visit per day. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered. *(See also Benefits for Mental Illness)*	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. Benefits are limited to one visit per day.	Paid as any other Sickness	

OTHER	Preferred Providers	Out-of-Network Providers
Elective Abortion	No Benefits	
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy. *(See Benefits Mastectomy)*	Paid as any other Sickness	
Diabetes Services	See Benefits for the Management and Treatment of Diabetes	
TMJ Disorder	Paid as any other Sickness	
Needle Stick/Blood & Body Fluid and Infectious Disease Exposure, *(Benefits are limited to Insured students for an exposure to blood/body fluid/infectious disease during a clinical rotation by any route.)*	80% of PA	No Benefits
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*. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.	100% of PA	100% of U&C

UnitedHealthcare Network Pharmacy Benefits

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

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com/usg or call 877-417-7345 for the most up-to-date tier status.

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

$30 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

$50 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

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

Please present your ID card to the network pharmacy when the prescription is filled.

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

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

Additional Exclusions

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

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

Definitions

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

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com/usg or call Customer Service at 1-877-417-7345.

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 us at 1-866-403-8267 and/or by asking the provider when making an appointment for services.

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

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

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

Inpatient Expenses

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

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

Maternity Testing

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

Initial screening at first visit:

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

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester

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

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

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

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-866-403-8267.

Coordination of Benefits Provision

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

Mandated Benefits

Benefits for Mammography

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

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

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

a. Who has a personal history of breast cancer;

b. Who has a personal history of biopsy proven benign breast disease;

c. Whose grandmother, mother, sister, or daughter has had breast cancer; or

d. Who has not given birth prior to the age of 30.

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

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

Benefits for Pap Smears

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

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

Benefits for Prostate-Specific Antigen (PSA) Tests

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

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

Benefits for Mental Illness

Benefits will be paid the same as any other Sickness for Mental Illness treatment.

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

Benefits for Bone Marrow Transplants

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

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

Benefits for Mastectomy

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

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

Benefits for Bone Mass Measurement

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

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

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

Benefits for Colorectal Cancer Screening

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

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

Benefits for Dental Anesthesia

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

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

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

Benefits for the Management and Treatment of Diabetes

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

"Pharmacologic agents" include:

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

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

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

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

1. Test strips for glucose monitors, which include test strips whose performance achieved clearance by the FDA;
2. Visual reading and urine testing strips, which includes visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones;
3. Lancets and single use lancing devices used in conjunction with the monitoring of glycemic control;
4. Syringes, which includes insulin syringes, insulin injection needles for use with pen-like insulin injection devices and other disposable parts required for insulin injection aids;

5. Medical supplies for use with insulin pumps and insulin infusion pumps to include disposable devices to assist with the injection of insulin and infusion sets, alcohol swabs and related preparations and other similar compounds associated with the cleansing of injection sites prior to the administration of insulin; and
6. Such other single-use medical supplies that are Medically Necessary and consistent with the current standards of care of the American Diabetes Association.

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

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

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

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

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

1. Upon a Physician's diagnosis that an Insured Person has diabetes;
2. Upon a significant change in an Insured Person's diabetes related condition;
3. Upon a change in an Insured Person's diagnostic levels;
4. Upon a change in treatment regimen;
5. Upon an Insured Person's initiation of insulin therapy;
6. Upon identification of inadequate diabetes control as evidenced by diagnostic laboratory tests falling outside of acceptable ranges;
7. Upon determination that an Insured Person is at high risk for complications based on inadequate glycemic control documented by acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the Insured Person's history during which the insured Person needed emergency room visits or hospitalization;

8. Upon determination that an Insured Person is at high risk based on at least one of the documented diabetes related complications, including:
    a. Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation;
    b. Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye;
    c. Kidney complications related to diabetes, when manifested by albuminuria without other cause, or elevated creatinine.

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

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

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

Benefits for Surveillance Tests for Ovarian Cancer

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

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

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

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

Benefits for Telemedicine

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

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

Benefits for Drug Treatment of Children's Cancer

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

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

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

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

Benefits for Postpartum Care

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

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

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

Benefits for Chlamydia Screening

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

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

Definitions

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

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any. Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

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

INJURY means bodily injury which is all of the following:

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

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

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

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medial 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.

SICKNESS means illness or disease of an Insured Person which first manifests itself after the Effective Date of insurance and while the insurance is in force. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

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

Exclusions and Limitations

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

1. Biofeedback;
2. Cosmetic procedures, except 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;
3. Dental treatment, except as specifically provided in the Schedule of Benefits;
4. Elective Surgery or Elective Treatment;
5. 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;
6. Flat foot conditions; supportive devices for the foot, except as specifically provided in Benefits for the Management and Treatment of Diabetes; subluxations of the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including care, cutting and removal of corns, calluses, toenails and bunions (except capsular or bone surgery);
7. Hearing examinations; hearing aids; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
8. Hirsutism; alopecia;
9. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
10. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
11. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
12. Investigational services;
13. Organ transplants, including organ donation;
14. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
15. 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 Benefits for Drug Treatment for Children’s Cancer;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;

16. Reproductive/Infertility services including but not limited to: family planning, except contraceptives; fertility tests; infertility (male or female), except Covered Medical Expenses relating to diagnosis, 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;
17. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
18. Deviated nasal septum, including submucous resection and/or other surgical correction thereof;
19. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
20. Sleep disorders;
21. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
22. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
23. 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
24. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

Collegiate Assistance Program

Insured Students have access to nurse advice and health information 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

Scholastic Emergency Services: Global Emergency Medical Assistance

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

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

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

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

Key Services include:

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

Please log into your online account at www.uhcsr.com/usg for additional information on SES Global Emergency Assistance Services, including service descriptions and program exclusions and limitations.

To access services please call:

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

(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

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

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

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at www.uhcsr.com/usg for additional information, including limitations and exclusions pertaining to the SES program.

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, Explanation of Benefits, correspondence and coverage information via My Account at www.uhcsr.com/usg. Insureds can also print a temporary ID card, request a replacement ID card and locate network providers from My Account. You may also access the most popular My Account features from your smartphone at our mobile site: my.uhcsr.com/usg.

If you don't already have an online account, simply select the "Create an Account" link from the home page at www.uhcsr.com/usg. 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.uhcsr.com/usg to access your account information.

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 866-403-8267 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Appeal.

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:

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

To request an Expedited Internal Appeal, please contact Claims Appeals at 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

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

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

Standard External Review

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

Expedited External Review

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

Where to Send External Review Requests

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

Attention: Independent Review Requests

Office of General Counsel/Division of Health Planning

Georgia Department of Community Health

2 Peachtree Street NW

5th Floor

Atlanta, Georgia 30303-3142

(404) 656-0409

http://dch.georgia.gov

Questions Regarding Appeal Rights

Contact Customer Service at 866-403-8267 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state department of insurance may be able to assist you at:

Georgia Office of Insurance and Safety Fire Commissioner

Consumer Services Division

2 Martin Luther King, Jr. Drive

West Tower, Suite 716

Atlanta, GA 30334

(800) 656-2298

http://www.oci.ga.gov/ConsumerService/Home.aspx

Claim Procedure

In the event of Injury or Sickness, the student should:

1. Report to the Student Health Center or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-866-403-8267

customerservice@uhcsr.com

claims@uhcsr.com

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

This Certificate is based on Policy Number: 2012-1187-1

Savannah State University

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2012-1187-1

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

NOC 2 (11/20/19)

1. Removed the following language 'Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered' from the line item for Substance Use Disorder Treatment'.

NOC 1 (8/29/12)

1. Removed exclusion #2 "Congenital conditions, except as specifically provided for Newborn or adopted Infants;"