

CERTIFICATE OF COVERAGE

2013-2014

STUDENT INJURY AND SICKNESS INSURANCE PLAN

EXCESS INSURANCE

DESIGNED ESPECIALLY FOR THE STUDENTS OF



THIS PLAN IS UNDERWRITTEN BY UNITEDHEALTHCARE INSURANCE COMPANY

THIS CERTIFICATE CONTAINS A DEDUCTIBLE
PROVISION



TOLL-FREE NUMBER FOR INQUIRIES: FOR INQUIRIES AND TO OBTAIN INFORMATION ABOUT YOUR COVERAGE, OR FOR ASSISTANCE IN RESOLVING A COMPLAINT, PLEASE CALL (800) 505-4160.

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2012 and \$500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of \$500,000 for each Injury or Sickness that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-505-4160. 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 copy of our privacy practices by calling us toll-free at 1-800-505-4160 or visiting us at www.firststudent.com.

Eligibility

All students taking credit hours are eligible to enroll in this insurance Plan. All international students attending Stetson University are required to purchase this insurance Plan unless proof of comparable coverage is furnished.

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

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse or Domestic Partner and their children under 26 years of age. The Named Insured may also cover a dependent child to the end of the year in which the Dependent reaches age 30 under certain circumstances. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 12, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 11, 2014. 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.

Annual Rates

Student:	\$1,737.00
Spouse:	\$5,574.00
Each Child:	\$3,560.00

Extension of Benefits After Termination

The coverage provided under the policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury or Sickness for which benefits are payable 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 12 months after the Termination Date.

However, 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.

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

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

Pre-Admission Notification

UniteHealthcare 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.

UniteHealthcare 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

**Up To \$500,000 Maximum Benefit Paid As Specified Below
(For each Injury or Sickness)**

Deductible Preferred Providers: \$150 (Per Insured Person) (Per Policy Year)
Deductible Out-of-Network: \$400 (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)
Out-of-Pocket Maximum Out-of-Network: \$10,000 (Per Insured Person, 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 Basic Maximum Benefit of \$500,000 for each Injury or Sickness.

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 Copays and per service Deductibles, and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. The policy Deductible will be applied to 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.

NOTE: No benefits will be paid for services designated as "No Benefits" in the Schedule.

The benefits payable are as defined in and subject to all provisions of the policy and any riders or 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 scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated below. Covered Medical Expenses include:

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.	90% of PA	70% of U&C
Intensive Care	90% of PA	70% of U&C
Routine Newborn Care , while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	

INPATIENT	Preferred Providers	Out-of-Network Providers
Assistant Surgeon	90% of PA	70% of U&C
Anesthetist , professional services in connection with inpatient surgery.	90% of PA	70% of U&C
Registered Nurse's Services , private duty nursing care.	90% of PA	70% of U&C
Physician's Visits , non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	90% of PA	70% of U&C
Pre-Admission Testing , payable within 3 working days prior to admission.	90% of PA	70% 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.	90% of PA	70% of U&C
Physiotherapy	90% of PA	70% of U&C
OUTPATIENT		
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.	90% of PA	70% 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.	90% of PA	70% of U&C
Assistant Surgeon	90% of PA	70% of U&C
Anesthetist , professional services administered in connection with outpatient surgery.	90% of PA	70% of U&C
Physician's Visits , benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	90% of PA	70% of U&C
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.	90% of PA	70% of U&C
Physiotherapy , physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy unless excluded in the policy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness	90% of PA	70% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Diagnostic X-ray Services	90% of PA	70% of U&C
Laboratory Services	90% of PA	70% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	90% of PA	70% 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.	90% of PA	70% of U&C
Chemotherapy	90% of PA	70% of U&C
Radiation Therapy	90% of PA	70% of U&C
Prescription Drugs	100% of U&C / \$15 Deductible per prescription for generic drugs / \$40 Deductible per prescription for brand name / up to a 31 day supply per prescription	
OTHER		
Ambulance Services	90% of PA	90% 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. (\$1,000 maximum Per Policy Year.) (Durable Medical Equipment benefits payable under the \$1,000 maximum Per Policy Year are not included in the \$500,000 Maximum Benefit.)	90% of PA	70% of U&C
Consultant Physician Fees, when requested and approved by the attending Physician.	90% of PA	70% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. (\$1,000 maximum Per Policy Year.) (Benefits are not included in the \$500,000 Maximum Benefit.)	90% of U&C	90% of U&C
Maternity. benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	

OTHER

Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy. <i>(See Benefits for Mastectomies, Prosthetic Devices and Reconstructive Surgery.)</i>	Paid as any other Sickness	
Diabetes Services, in connection with the treatment of diabetes.	Paid as any other Sickness	
Mental Illness Treatment, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	
Preventive Care, 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 Preferred Allowance	No Benefits

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.

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 1-800-505-4160.

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.

For Loss Of:

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

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

Excess Provision

Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, 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 as a result of the Insured's failure to comply with policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

Mandated Benefits

Benefits for Outpatient Services

Benefits will be provided for treatment performed outside a Hospital for any Injury or Sickness as defined in the policy provided that such treatment would be covered on an Inpatient basis and is provided by a health care provider whose services would be covered under the policy if the treatment were performed in a Hospital. Treatment of the Injury or Sickness must be a Medical Necessity and must be provided as an alternative to Inpatient treatment in a Hospital. Reimbursement is limited to amounts that are Usual and Customary for the treatment or services.

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

Benefits for Procedures Involving Bones or Joints of the Jaw and Facial Region

Benefits will be paid the same as any other Injury or Sickness for diagnostic or surgical procedures involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is Medically Necessary to treat conditions caused by Injury Sickness or congenital or developmental deformity.

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

Benefits for Post Delivery Care for a Mother and Her Newborn Infant

Benefits will be paid the same as any other Sickness for postdelivery care for a mother and her Newborn Infant. Benefits for postdelivery care shall include a postpartum assessment and newborn assessment and may be provided at the Hospital, at licensed birth centers, at the Physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. Benefits shall include physical assessment of the newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

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

Benefits for Diabetes

Benefits will be provided for all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the patient's treating Physician or a Physician who specializes in the treatment of diabetes certifies that such services are necessary. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. Nutrition counseling must be provided by a licensed dietitian.

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

Benefits for Mammography

Benefits will be paid the same as any other Sickness for a mammogram according to the following guidelines:

1. One baseline mammogram for women age thirty-five to thirty-nine, inclusive.
2. A mammogram for women age forty to forty-nine, inclusive, every 2 years or more frequently based on the patient's Physician's recommendation.
3. A mammogram every year for women age fifty and over.
4. One or more mammograms a year upon a Physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.
5. Benefits are paid, with or without a Physician prescription, if the Insured obtains a mammogram in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health and Rehabilitative Services for breast-cancer screening.

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

Benefits for Mastectomies, Prosthetic Devices and Reconstructive Surgery

Benefits will be paid the same as any other Sickness for Mastectomy, prosthetic devices, and Reconstructive Surgery incident to the Mastectomy. Breast Reconstructive Surgery must be in a manner chosen by the treating Physician, consistent with prevailing medical standards, and in consultation with the patient.

"Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician, and the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts.

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

Benefits for Post-Surgical Mastectomy Care

Benefits will be paid the same as any other Sickness for outpatient postsurgical follow-up care in keeping with prevailing medical standards by a Physician qualified to provide postsurgical mastectomy care. The treating Physician, after consultation with the Insured, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the Hospital, treating Physician's office, outpatient center, or home of the Insured.

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

Benefits for Osteoporosis

Benefits will be paid the same as any other Sickness for the Medically Necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism and individuals who have a family history of osteoporosis.

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

Benefits for Child Health Assurance

The benefits applicable for Dependent children shall include coverage for Child Health Supervision Services from the moment of birth to 16 years of age.

"Child Health Supervision Services" means Physician-delivered or Physician-supervised services which shall include as the minimum benefit coverage for services delivered at the intervals and scope stated below:

Child Health Supervision Services shall include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Minimum benefits are limited to one visit payable to one provider for all services provided at each visit.

Benefits shall not be subject to the Deductible, but are subject to all Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Cleft Lip and Cleft Palate

Benefits will be paid the same as any other Sickness for a child under the age of 18 for treatment of cleft lip and cleft palate. The benefit will include medical, dental, speech therapy, audiology, and nutrition services if such services are prescribed by the treating Physician and such Physician certifies that such services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

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

Benefits for Newborn Infant, Adopted or Foster Child

Newborn Infant All health insurance benefits applicable for children will be payable with respect to a child born to the Named Insured or Dependents after the Effective Date and while the coverage is in force, from the moment of birth. However, with respect to a Newborn Infant of a Dependent other than the Insured Person's spouse, the coverage for the Newborn Infant terminates 18 months after the birth of the Newborn Infant. The coverage for Newborn Infant consists of coverage for Injury or Sickness including necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation cost of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending Physician as necessary to protect the health and safety of the Newborn Infant. The coverage of such transportation may not exceed the Usual and Customary Charges, up to \$1,000.

The Insured may notify the Company, in writing of the birth of the child not less than 30 days after the birth. If timely notice is given, the Company may not charge an additional premium for coverage of the Newborn Infant for the duration of the notice period. If timely notice is not given, the Company may charge the applicable additional premium from the date of birth. The Company will not deny coverage for a child due to failure to timely notify the Company of the child.

Adopted or Foster Child The Named Insured's adopted child or foster child will be covered to the same extent as other Dependents from the moment of placement in the residence of the Named Insured. In the case of a newborn adopted child, coverage begins at the moment of birth and applies as for a newborn infant defined above if a written agreement to adopt such child has been entered into by the Named Insured prior to the birth of the child whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Named Insured's residence. The Pre-existing Conditions limitation will not apply to an adopted child,

but will apply to a foster child. The Insured may notify the Company, in writing, of the adopted or foster child not less than 30 days after placement or adoption. If timely notice is given, the Company may not charge an additional premium for coverage of such child for the duration of the notice period. If timely notice is not given, the Company may charge the applicable additional premium from the date of adoption or placement. The Company will not deny coverage for a child due to failure to timely notify the Company of such child.

Benefits will also be provided for a foster child or other child placed in court-ordered temporary or other custody of the Insured from the moment of placement.

Benefits for Hospital Dental Procedures

Benefits will be paid the same as any other Sickness for general anesthesia and hospitalization services for dental treatment or surgery that is considered necessary when the dental condition is likely to result in a medical condition if left untreated. The necessary dental care shall be provided to an Insured who:

1. Is under 8 years of age and is determined by a licensed dentist, and the child's Physician to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
2. Has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center.

This benefit does not include the diagnosis or treatment of dental disease.

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

Definitions

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

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

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

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

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement 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.

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

The Named Insured may continue to cover a dependent child to the end of the calendar year in which the Dependent reaches age 30, if the Dependent:

- 1) Is unmarried and does not have any dependents of his/her own;
- 2) Is a resident of the state of Florida or a full-time or part-time student; and
- 3) Is not covered under any other group or blanket health insurance policy or is not entitled to benefits under Title XVIII of the Social Security Act.

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; and,
- 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).

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

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.

INJURY means bodily injury which is all of the following:

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

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

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

MEDICAL EMERGENCY means 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 and permanent 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.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

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

PRE-EXISTING CONDITION means any condition which manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months immediately prior to the Insured's Effective Date under this policy. Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

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 where service is rendered. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions and Limitations

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. Acupuncture;
3. Allergy including allergy testing;
4. 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;
5. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation;
6. Congenital conditions, except as specifically provided under Benefits for Newborn Infant, Adopted or Foster Child or Benefits for Cleft Lip and Cleft Palate;
7. 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;
8. 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;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery or Elective Treatment, except cosmetic surgery made necessary as the result of a covered Injury or to correct a disorder of a normal bodily function;
11. Elective abortion;
12. 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 or except as specifically provided in the policy or under Benefits for Newborn Infant, Adopted or Foster Child or Benefits for Child Health Assurance;
13. Flat foot conditions; supportive devices for the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);
14. Health spa or similar facilities; strengthening programs;
15. Hearing examinations or hearing aids; or other treatment for hearing defects and problems, except as specifically provided under Benefits for Cleft Lip and Cleft Palate or Benefits for Newborn Infant, Adopted or Foster Child, or Benefits for Child Health Assurance. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
16. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
17. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
18. Injury sustained while (a) participating in any intercollegiate sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
19. Investigational services;
20. Experimental organ transplants; if not experimental in nature, organ transplants will be covered as any other Sickness; organ donation;

21. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting, except in self-defense;
22. Pre-existing Conditions will apply for the first 6 months, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. Credit will be given for the time the Insured was covered under a previous similar plan if the previous coverage was continuous to a date not more than 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;
23. 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;
 - 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.
24. 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;
25. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;
26. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
27. 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;
28. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
29. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of chronic purulent sinusitis;
30. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
31. Sleep disorders;
32. Speech therapy, except as specifically provided in Benefits for Cleft Lip and Cleft Palate; naturopathic services;
33. Suicide or attempted suicide while sane or insane; or intentionally self-inflicted Injury;
34. Supplies, except as specifically provided in the policy;

35. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
36. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
37. 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
38. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

FrontierMEDEX: Global Emergency Services

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

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

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

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

Key Services include:

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

Please visit www.firststudent.com for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(800) 527-0218 Toll-free within the United States

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

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

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

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

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 800-505-4160 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 of care, or effectiveness.

Standard External Review

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

Expedited External Review

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

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

Standard Experimental or Investigational External Review

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

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

Expedited Experimental or Investigational External Review

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

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
 - a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
 - b. Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly; or

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

Where to Send External Review Requests

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

Claims Appeals
UnitedHealthcare StudentResources
PO Box 809025
Dallas, TX 75380-9025
888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service 800-505-4160 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Online Access to Account Information

UnitedHealthcare **StudentResources** Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to **My Account** at www.firststudent.com. Insured students who don't already have an online account may simply select the "My Account" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare **StudentResources**' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

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

UnitedHealth Allies

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

ID Cards

One way we are becoming greener is to no longer automatically mail out **ID Cards**. Instead, we will send an email notification when the digital ID card is available to be downloaded from **My Account**. An Insured student may also use **My Account** to request delivery of a permanent ID card through the mail. ID Cards may also be accessed via our mobile site at my.uhcsr.com.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed 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.

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, SR 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.

The Plan is Underwritten by

UnitedHealthcare Insurance Company

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

Sales/Marketing Services:

UnitedHealthcare **Student**Resources

805 Executive Center Drive West, Suite 220

St. Petersburg, FL 33702

1-800-237-0903

E-Mail: info@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 # 2013-200433-1