

2010-2011

STUDENT  
INJURY AND SICKNESS  
INSURANCE PLAN

DESIGNED ESPECIALLY FOR THE STUDENTS AT MEMBER COLLEGES OF THE

MISSOURI COMMUNITY  
COLLEGE ASSOCIATION



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## **Privacy Policy**

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We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a detailed copy of our privacy policy by calling us toll-free at 1-800-767-0700 or by visiting us [www.uhcsr.com](http://www.uhcsr.com).

## **Eligibility**

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Registered international students, visiting faculty, scholars or other persons who are in the United States on a visa issued for scholarly/educational purposes and with a current passport, who are temporarily residing outside their home country 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, Internet and television (TV) 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 may also insure their Dependents. Eligible Dependents are the spouse or Domestic Partner and unmarried children under 26 years of age who are not self-supporting. 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**

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The Master Policy becomes effective August 1, 2010. 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 July 31, 2011. 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**

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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 were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

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

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

## Schedule of Medical Expense Benefits

### Injury and Sickness

\$250,000 Maximum Benefit (Student) (For each Injury or Sickness)

\$100,000 Maximum Benefit (Dependent) (For each Injury or Sickness)

Deductible \$200 (Per Insured Person) (Per Policy Year)

The Policy provides benefits for the Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of \$250,000 for each Injury or Sickness.

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses 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.

After the Deductible has been satisfied, the Company will pay 80% of Preferred Allowance for Preferred Providers and 60% of Usual & Customary Charges for Out-of-Network Providers up to the out-of-pocket maximum of \$5,000 for each Injury or Sickness. Once the Insured out-of-pocket maximum has been satisfied, additional Covered Medical Expenses will be paid at 100% of Preferred Allowance for Preferred Providers and 100% of Usual & Customary Charges for Out-of-Network Providers, up to the policy Maximum Benefit.

Exclusions will be waived and benefits will be provided for the repair or replacement of eyeglasses, contact lenses or hearing aids when damaged as a result of a covered Injury.

Note: The individual benefit co-pays / Deductibles are in addition to the Policy year Deductibles.

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 noted below. Covered medical expense include:

INPATIENT	Preferred Providers	Out of Network
<p><b>Hospital Expense</b>, daily semi-private room rate; and general nursing care provided by the Hospital. Hospital Miscellaneous Expense such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services &amp; supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.</p>	Preferred Allowance	Usual & Customary Charges
<p><b>Intensive Care</b></p>	Preferred Allowance	Usual & Customary Charges
<p><b>Routine Newborn Care</b>, while Hospital Confined; and routine nursery care provided immediately after birth.</p>	See Benefits for Maternity Expenses	
<p><b>Physiotherapy</b></p>	Paid under Hospital Expense	

INPATIENT	Preferred Providers	Out of Network
<b>Surgery</b> , in accordance with data provided by Ingenix. 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 subsequent procedures.	Preferred Allowance	Usual & Customary Charges
<b>Assistant Surgeon</b>	Preferred Allowance	Usual & Customary Charges
<b>Anesthetist</b> , professional services in connection with inpatient surgery.	Preferred Allowance	Usual & Customary Charges
<b>Registered Nurse's Services</b> , private duty nursing care.	No Benefits	
<b>Physician's Visits</b> , benefits are limited to one visit per day and do not apply when related to surgery.	Preferred Allowance	Usual & Customary Charges
<b>Pre-Admission Testing</b> , payable within 3 working days prior to admission.	Preferred Allowance	Usual & Customary Charges
<b>Mental Illness</b> , psychiatric Hospitals are not covered.	See Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse	
OUTPATIENT		
<b>Surgery</b> , in accordance with data provided by Ingenix. 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 subsequent procedures.	Preferred Allowance	Usual & Customary Charges
<b>Assistant Surgeon</b>	Preferred Allowance	Usual & Customary Charges
<b>Day Surgery Miscellaneous</b> , related to surgery performed in a Hospital, including the cost of the operating room; laboratory tests & x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual & Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Usual & Customary Charges
<b>Anesthetist</b> , professional services administered in connection with outpatient surgery.	Preferred Allowance	Usual & Customary Charges

OUTPATIENT	Preferred Providers	Out of Network
<p><b>Physician's Visits</b>, benefits are limited to one visit per day and do not apply when related to surgery or Physiotherapy <i>(The \$20 copay/Deductible per visit is waived if referred by the Student Health Center.)</i></p>	<p>Preferred Allowance / \$20 copay per visit</p>	<p>Usual &amp; Customary Charges / \$20 Deductible per visit</p>
<p><b>Physiotherapy</b>, benefits are limited to one visit per day. <i>(20 visits maximum)</i> There are no benefits for treatment that is not considered medically necessary as defined under this policy.</p>	<p>Preferred Allowance</p>	<p>Usual &amp; Customary Charges</p>
<p><b>Medical Emergency Expenses</b>, use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. <i>(Copay/Deductible waived if admitted)</i></p>	<p>80% of Preferred Allowance / \$50 copay per visit</p>	<p>80% of Usual &amp; Customary Charges/ \$50 Deductible per visit</p>
<p><b>Diagnostic X-Ray &amp; Laboratory Services</b></p>	<p>Preferred Allowance / \$20 copay per visit</p>	<p>Usual &amp; Customary Charges / \$20 Deductible per visit</p>
<p><b>Injections</b>, when administered in the Physician's office and charged on the Physician's statement.</p>	<p>Preferred Allowance</p>	<p>Usual &amp; Customary Charges</p>
<p><b>Tests &amp; Procedures</b>, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays &amp; Lab Procedures.</p>	<p>Preferred Allowance / \$20 copay per visit</p>	<p>Usual &amp; Customary Charges / \$20 Deductible per visit</p>
<p><b>Radiation Therapy / Chemotherapy</b></p>	<p>Preferred Allowance / \$20 copay per visit</p>	<p>Usual &amp; Customary Charges / \$20 Deductible per visit</p>
<p><b>Prescription Drugs</b> if a covered Prescription Drug is prescribed in a single dosage amount and the drug is not manufactured in such single dosage amount and requires dispensing in a combination of different manufactured dosage amounts only one co-payment or Deductible for the dispensing of the combination of the manufactured dosages that equal the prescribed dosage for such Prescription Drug will apply. A new co-payment or Deductible will apply to each 31 day supply of the Prescription Drug. Mail order Prescription Drugs are also available through UnitedHealthcare Network Pharmacy at 2.5 times the retail copay up to a 90 day supply. <i>(Includes Contraceptives.)</i></p>	<p>UnitedHealthcare Network Pharmacy (UHPS) \$10 copay - per prescription for Tier 1 / \$25 copay - per prescription for Tier 2 / 50% coinsurance per prescription for Tier 3 / \$1,000 maximum Per Policy Year</p>	<p>No Benefits</p>
<p><b>Mental Illness</b>, benefits are limited to one visit per day.</p>	<p>See Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse</p>	

OTHER	Preferred Providers	Out of Network
<b>Ambulance Services</b> <i>(\$750 maximum per Injury or Sickness)</i>	Preferred Allowance	80% of Usual & Customary Charges
<b>Consultant Physician Fees</b> , when requested and approved by the attending Physician.	Preferred Allowance / \$20 copay per visit	Usual & Customary Charges / \$20 Deductible per visit
<b>Durable Medical Equipment</b>	Preferred Allowance	80% of Usual & Customary Charges
<b>Dental Treatment</b> , made necessary by Injury to Sound, Natural Teeth. <i>(\$250 per tooth maximum)</i>	Usual & Customary Charges	80% of Usual & Customary Charges
<b>Alcoholism</b>	See Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse	
<b>Chemical Dependency</b>	See Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse	
<b>Maternity</b>	See Benefits for Maternity Expenses	
<b>Elective Abortion</b>	See Elective Abortion Benefits	
<b>Complications of Pregnancy</b>	Paid as any other Sickness	
<b>Acupuncture</b> <i>(\$35 per day maximum / 10 visits maximum)</i>	Preferred Allowance	Usual & Customary Charges
<b>Vision &amp; Hearing</b> for the repair or replacement of eyeglasses, contact lenses or hearing aids when damaged as a result of a covered Injury.	Preferred Allowance	Usual & Customary Charges

## **UnitedHealthcare Network Pharmacy Benefits**

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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 is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access [www.uhcsr.com](http://www.uhcsr.com) or call 1-877-417-7345 for the most up-to-date tier status.

\$10 copay per prescription order or refill for a Tier 1 Prescription Drug up to 31 day supply

\$25 copay per prescription order or refill for a Tier 2 Prescription Drug up to 31 day supply

50% coinsurance per prescription order or refill for a Tier 3 Prescription Drug up to 31 day supply

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

Your maximum allowed benefit is \$1,000 per Policy year

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](http://www.uhcsr.com) and log in to your online account or call 1-877-417-7345.

### **Additional Exclusions**

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.

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

## Definitions

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

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

## **Preferred Provider Information**

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

UnitedHealthcare Options PPO

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 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

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

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

### **Inpatient Hospital Expenses**

**PREFERRED HOSPITALS** - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified in the schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call 1-800-767-0700 for information about Preferred Hospitals.

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

### **Outpatient Hospital Expenses**

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

### **Professional & Other Expenses**

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

## **Maternity Testing**

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This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered, if all other policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/AFP Screening and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

## **Accidental Death and Dismemberment Benefits**

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### **Loss of Life, Limb or Sight**

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below. Payment under this benefit will not exceed the policy Maximum Benefit.

#### **For Loss of:**

	<b><u>Student</u></b>	<b><u>Dependents</u></b>
Life	\$10,000	\$5,000
Two or More Members	\$10,000	\$5,000
One Member	\$ 5,000	\$2,500
Thumb or Index Finger	\$ 2,500	\$1,250

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.

## **Mandated Benefits**

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

Benefits will be paid the same as any other Sickness for Low-dose Mammography for the presence of occult breast cancer. Benefits will be provided according to the following guidelines:

1. A single baseline mammogram for women thirty-five to thirty-nine years of age.
2. A mammogram not less than once every two years for women forty to forty-nine years of age or more often for women with risk factors to breast cancer if recommended by her Physician.
3. A mammogram every year for women fifty and over.
4. A mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer.

**“Low-dose mammography”** means the x-ray examination of the breast, using equipment dedicated specifically for mammography including but not limited to the x-ray tub, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

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

### ***Benefits for Prosthetic Device and Reconstructive Surgery***

Benefits will be paid the same as any other Sickness for a Mastectomy and the initial prosthetic device or reconstructive surgery necessary to restore symmetry incident to the Mastectomy when recommended by a Physician.

No time limit shall be imposed on an Insured Person for the receipt of prosthetic devices or reconstructive surgery while covered under the policy.

“Mastectomy” means the removal of all or part of the breast for medically necessary reasons as determined by a Physician.

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

### ***Benefits for Cytologic Screening***

Benefits will be paid the same as any other Sickness for a pelvic examination and cytologic screening (pap smear) for an Insured in accordance with the current American Cancer Society guidelines.

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 a colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic Insured Person in accordance with the current American Cancer Society guidelines.

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

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

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer for an Insured in accordance with the current American Cancer Society guidelines.

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

### ***Benefits for Second Opinion for Newly Diagnosed Cancer***

Benefits will be paid the same as any other Sickness for a second opinion rendered by a Physician specializing in that specific cancer diagnosis area when an Insured with a newly diagnosed cancer is referred to such Physician specialist by his or her attending Physician.

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

### ***Benefits for Clinical Trial for Cancer Treatment***

Benefits will be paid the same as any other Sickness for the medically necessary treatment for Routine Patient Care Costs associated with Cancer Clinical Trials.

The provisions of this section shall not be construed to affect compliance or coverage for off-label use of drugs not directly affected by this section.

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

A detailed description of the benefits and restrictions for Cancer Clinical Trials is available in the Master Policy on file at the school or by calling the Company at 1-800-767-0700.

### ***Benefits for Osteoporosis***

Benefits will be paid the same as any other Sickness for services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a Physician for Insureds with a condition or medical history for which bone mass measurement is medically indicated. In determining whether testing or treatment is medically appropriate, due consideration will be given to peer reviewed medical literature.

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

### ***Human Leukocyte Antigen Testing Benefit***

Benefits will be paid the same as any other Sickness for Human Leukocyte Antigen Testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Benefits will be limited to one such testing per lifetime, not to exceed \$75.00.

The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists.

At the time of testing, the Insured being tested must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

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

### ***Benefits for Immunizations***

Benefits will be paid the same as any other Sickness for immunizations of a child from birth to five years of age as provided by department of health regulations.

Benefits shall not be subject to any Deductible or copayment limits.

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

Benefits will be paid the same as any other Sickness for formula and Low Protein Modified Food Products recommended by a Physician for the treatment of phenylketonuria (PKU) or any inherited disease of amino and organic acids for an Insured less than six (6) years of age. Benefits will not exceed \$5,000 per policy year.

"Low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

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

### ***Contraceptive Benefit***

The Policyholder provides benefits for Contraceptives the same as any other Prescription Drug or device under this policy.

“Contraceptives” means all prescription drugs and devices approved by the Federal Food and Drug Administration for use as a contraceptive but shall exclude all drugs and devices that are intended to induce an abortion.

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

If, for moral, ethical or religious beliefs, you do not want benefits for contraceptive drugs or devices, contact the Company at 1-800-767-0700.

### ***Benefits for Newborn Hearing Screening***

Benefits will be paid the same as any other Sickness for Dependent Newborn Infants for hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

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

### ***Benefits for Dental General Anesthesia***

Benefits will be paid the same as any other Sickness for administration of general anesthesia and Hospital charges for dental care to a Dependent child under the age of five, an Insured who is severely disabled, or an Insured who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

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

### ***Benefits for Maternity Expenses***

Benefits will be paid the same as any other Sickness for a minimum of 48 hours for inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery. Post-discharge care will be payable for up to two visits, one of which shall be in the home. A Physician shall determine the location and schedule of the post-discharge visits. Services shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization.

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

## **Additional Benefits**

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### ***Benefits for Treatment of Mental Illness, Alcohol and Drug Abuse***

Benefits will be paid the same as any other Sickness for medically necessary recognized Mental Illness treatment by a Physician.

"Mental Illness" as used in this benefit provision means the following disorders contained in the International Classification of Diseases (ICD-9-CM): (a) Schizophrenic disorders and paranoid states (295 and 297, except 297.3); (b) Major depression, bipolar disorder, and other affective psychoses (296); (c) Obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81); (d) Early childhood psychoses, and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314); (e) Alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); (f) Anorexia nervosa, bulimia and other severe eating disorders (307.1, 307.51, 307.52 and 307.53); and (g) Senile organic psychotic conditions (290).

### **Additional Limitations and Exclusions:**

Alcohol and Drug Abuse treatment services are limited to a minimum of thirty (30) days total inpatient treatment and a minimum of twenty (20) total visits for outpatient treatment for each Policy Year. The Lifetime Maximum is limited to four times the Policy Year maximum. The days allowed for inpatient treatment can be converted for use for outpatient treatment on a two-for-one basis.

No benefits will be paid for: (1) Marital, family, educational, or training services unless medically necessary and clinically appropriate; (2) Services rendered or billed by a school or halfway house; (3) Care that is custodial in nature; (4) Services and supplies that are not medically necessary nor clinically appropriate; or (5) Treatments that are considered experimental.

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

### ***Elective Abortion Benefit***

#### **Named Insured Only**

Benefits will be paid for elective abortion as for any other Sickness not to exceed \$500 maximum per policy year.

This coverage is afforded only to the Named Insured. Dependents are excluded from the benefits of this endorsement.

## Definitions

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**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.

**INJURY** means accidental bodily injury sustained, directly and independently of all other causes; treated by a Physician within 30 days after the date of accident and while the Insured Person is covered under this policy. 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.

**MEDICAL EMERGENCY** means the occurrence of a sudden, and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

- 1) Placing the Insured's health in significant jeopardy;
- 2) Serious impairment of bodily functions;
- 3) Serious dysfunction of any body organ or part;
- 4) Inadequately controlled pain; or
- 5) With respect to a pregnant woman who is having contractions:
  - a. that there is inadequate time to effect a safe transfer to another Hospital before delivery; or
  - b. that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child

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

**SICKNESS** means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

**TOTALLY DISABLED** means a condition of a Named Insured which, because of Sickness or Injury, renders the Named Insured unable to actively attend class. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

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

## **Exclusions and Limitations**

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

1. Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
2. Autistic disease of childhood, hyperkinetic syndromes, milieu therapy, learning disabilities, behavioral problems, parent-child problems, attention deficit disorder, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the policy;
3. Biofeedback;
4. Circumcision;
5. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
6. 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;
7. Dental treatment, except as specifically provided in Benefits for Dental General Anesthesia or for accidental Injury to Sound, Natural Teeth;
8. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
9. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
10. Unless coverage is elected by the Policyholder, hearing examinations or hearing aids; or other treatment for hearing defects and problems, except as specifically provided in Benefits for Newborn Hearing Screening. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
11. Hirsutism; alopecia;
12. 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;
13. Injury caused by, contributed to, or resulting from the use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
15. Injury sustained while (a) participating in any interscholastic, club, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

16. Organ transplants, including organ donation;
17. Marital or family counseling;
18. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
19. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months; The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy;
20. 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;
  - b) Immunization agents, 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 Benefits for Clinical Trial for Cancer Treatment;
  - 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;
21. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
22. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in Benefits for Clinical Trial for Cancer Treatment;

23. Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery; except as specifically provided in the policy;
24. 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;
25. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
26. 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;
27. Unless coverage is elected by the Policyholder, speech therapy; naturopathic services;
28. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
29. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; snowmobile; skiing; scuba diving; surfing; roller skating; riding in a rodeo according to the policy provisions;
30. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
31. 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
32. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

## **Collegiate Assistance Program**

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Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the access 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**

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

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

SES 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 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
- \* Care for Minor Children Left Unattended Due to a Medical Incident
- \* Prescription Assistance
- \* Critical Care Monitoring
- \* Return of Mortal Remains
- \* Transportation to Join Patient
- \* Interpreter and Legal Referrals

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

### **To access services please call:**

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

**(609) 452-8570** Collect outside the United States

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

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

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; 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](http://www.uhcsr.com) for additional information, including limitations and exclusions pertaining to the SES program.

## **Grievance Procedure**

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The following levels of review are available to Insured Persons or providers who have a complaint or a Grievance.

A **Grievance** means a written complaint submitted by or on behalf of an Insured Person regarding:

- the Company's decisions, policies or actions related to availability, delivery or quality of health care services;
- claims payment, handling or reimbursement for health care services;
- the contractual relationship between an Insured Person and the Company; or
- the outcome of an Adverse Determination.

An Adverse Determination means a determination that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, and the requested service is therefore denied, reduced or terminated.

The levels of review include:

**Informal Review.** An Insured Person may submit an oral complaint to the Company for Informal Review after an event that causes a dispute. The Company must respond to the Insured, his/her designated representative, or the provider in writing within thirty days after receiving the complaint and any additional information requested for the Informal Review. At any time during the Informal Review, the Insured Person may submit a written request for the complaint to be reviewed through the Formal Review Process.

**Formal Review.** The Formal Review process includes a First Level, Second Level and Expedited Review Process.

**First Level Review.** An Insured Person or his or her provider, in the event of an Adverse Determination, may submit a written Grievance to the Company for review. The Insured Person will not be allowed to attend, nor have a representative attend, a First Level Review. However, the Insured Person may submit written material for the review.

Upon receipt of a request for First Level Grievance Review, the Company will:

- (1) Acknowledge receipt of the Grievance in writing within ten working days;
- (2) Conduct a complete investigation of the Grievance within twenty working days after receipt of a Grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty working days after receipt of a Grievance, the Insured shall be notified in writing on or before the twentieth working day and the investigation shall be completed within thirty working days thereafter. The notice shall set forth the reasons for the additional time needed for the investigation;
- (3) Within five working days after the investigation is completed, the Company will have someone not involved in the circumstances giving rise to the Grievance or its investigation decide upon the appropriate resolution of the Grievance and notify the Insured in writing of the Company's decision regarding the Grievance and of the right to file an appeal for a Second Level Review. The notice shall explain the resolution of the Grievance and the right to appeal in terms which are clear and specific;
- (4) Within fifteen working days after the investigation is completed, notify the person who submitted the Grievance of the Company's resolution of said Grievance.

**Second Level Review.** The Second Level Review process is available to Insured Persons who are not satisfied with the outcome of the First Level Review. The Insured Person, his/her designated representative, or provider may attend the Second Level Review. Persons reviewing a Second Level Grievance that involves an appeal or a clinical issue will include a provider who has appropriate expertise, other enrollees, representatives of the health carrier that were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance, and where the Grievance involves an Adverse Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance. Review by the grievance advisory panel shall follow the same time frames as a First Level Review, except as provided for in an Expedited Review, if applicable. Any decision of the grievance advisory panel shall include notice of the Insured's, the Company's or the Master Policyholder's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office.

**Expedited Review.** The Insured Person or his or her representative may request an Expedited Review of a Grievance orally or in writing. This level of review is available only in situations where the time frames for the Informal Review, First Level Review or Second Level Review would seriously jeopardize the life or health of an Insured Person or would jeopardize the Insured Person's ability to regain maximum function. The Company will orally notify the Insured within seventy-two hours after receiving a request for an Expedited Review of the Company's decision. Written confirmation of its decision will be sent within three working days from the date of such notification.

Insured Persons, his/her designated representative, or a provider may contact the Director of the Missouri Department of Insurance for assistance at any time at 1-800-726-7390 or write to Missouri Department of Insurance, P.O. Box 690, 301 West High Street, Truman Building, Room 630, Jefferson City, Missouri 65102-0690.

## **Claim Procedure**

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In the event of Injury or Sickness, students should:

- 1) Report to the nearest Physician or Hospital.
- 2) Mail 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. A written notice of claim must be submitted to the address below within 90 days after expense is incurred, or as soon thereafter as reasonably possible. Upon receipt of a notice of claim, the Company will furnish the Insured the necessary forms for filing proof of loss. If the person making claim does not receive the necessary claim forms before the expiration of 15 days after first requesting such forms, the Insured shall be deemed to have complied with the requirements as to the proof of loss upon submitting to the Company within 90 days written proof covering the occurrence, character and extent of the loss for which claim is made.
- 3) File claim within 90 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service.
- 4) The Insured's failure to give notice within such time will not invalidate nor reduce any claim if it is shown that notice was given as soon as was reasonably possible. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

### **The Plan is Underwritten by:**

UnitedHealthcare Insurance Company

### **Submit all Claims or Inquiries to:**

UnitedHealthcare **Student**Resources

P. O. Box 809025

Dallas, Texas 75380-9025

1-800-767-0700

claims@uhcsr.com

customerservice@uhcsr.com

### **Sales/Marketing Service:**

UnitedHealthcare **Student**Resources

805 Executive Center Drive West, Suite 220

St. Petersburg, FL 33702

1-800-237-0903

e-mail: info@uhcsr.com

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

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the Missouri Community College Association 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# 2010-202001-4

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