# 2012-2013
# UnitedHealthcare Insurance Company
# Student Injury and Sickness Insurance Plan
# Description of Benefits
# Premier Plan

GEORGETOWN UNIVERSITY

Designed especially for the students of
Georgetown University

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

UnitedHealthcare
A UnitedHealth Group Company

12-BR-DC (32) 23-32-1

## 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 $300,000 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 1-877-362-5287. 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.

## OBTAINING ADMINISTRATIVE ASSISTANCE

| | |
|---|---|
| **ID cards, questions about health benefits, vision, or dental Plans, customer service issues, and to change your address after open enrollment** | Gallagher Koster<br>500 Victory Road<br>Quincy MA 02171<br>877-362-5287<br>617-479-0860<br>www.gallagherkoster.com<br>StudentInsurance@gallagherkoster.com |
| **Claim Submission and Questions for Medical and Prescription Claims** | UnitedHealthcare **Student**Resources<br>P.O. Box 809025<br>Dallas, TX 75380-9025<br>877-935-5437<br>GKClaims@uhcsr.com |
| **Online access to claims status, Explanation of Benefits, correspondence and coverage info via My Account** (if you do not have an account select the "Create an Account" link) | www.uhcsr.com |
| **Pre-Certification Requirements** | AdvoCare<br>800-525-8548 |
| **Enrollment, Eligibility and Continuation Plan** | GU Student Health Insurance Office<br>Georgetown University, 31 Henle Village<br>Washington, DC 20057-1101<br>202-687-4883<br>202-687-4955 (fax)<br>http://studentaffairs.georgetown.edu/insurance<br>8:30 a.m. to 4:30 p.m (EST) |
| **Premium payments are sent to Student Accounts and made payable to Georgetown University** | Georgetown University<br>Department 0717<br>Washington, D.C. 20073-0717 |

## ACCESSING THE PROVIDER NETWORKS

| | |
|---|---|
| **Student Health Center (SHC)** | Darnall Hall Ground Floor<br>3800 Reservoir Rd, NW<br>Washington, DC 20007<br>202-687-2200 (for appointments)<br>202-687-3100 (for immunizations) |
| **Counseling and Psychiatric Service (for appointments / information)** | Counseling & Psychiatric Services<br>1 Darnall Hall, 37th and O street, NW<br>Washington, D.C. 20057<br>202-687-6985 |
| **Urgent After Hours Medical & Mental Health Advice** | 202-444-PAGE |
| **Georgetown University Hospital Referral Line** | Inside Metro D.C. - 202-342-2400<br>Outside Metro D.C. - 866-745-2633 |
| **Collegiate Assistance Program** (24 hour medical advice) | 877-643-5130 |
| **UnitedHealthcare Options PPO Network**<br>**UnitedHealthcare Network Pharmacy** | 877-935-5437 or www.uhcsr.com<br>877-417-7345 or www.uhcsr.com |
| **Scholastic Emergency Services: Global Emergency Medical Assistance** | within the US - 877-488-9833<br>outside the US - 609-452-8570 (collect)<br>www.assistamerica.com |

# HEALTH INSURANCE FOR STUDENTS
# of
# GEORGETOWN UNIVERSITY

## 2012-2013


Please keep this brochure as a general summary of the insurance. The Master Policy 2012-32-1 on file at the University, contains all of the provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between the brochure and policy, the Master Policy will govern and control the payment of benefits.

This Program is underwritten by UnitedHealthcare Insurance Company and serviced by Gallagher Koster.

## Table of Contents


INTRODUCTION ..... 1
ENROLLMENT PROCEDURES ..... 2
Enrollment Requirements ..... 2
Tuition Statement ..... 2
ONLINE MyAccess ENROLLMENT ..... 2
If You Wish to Accept ..... 2
If You Wish to Waive ..... 2
CHECKLIST FOR HEALTH INSURANCE COVERAGE ..... 3
STUDENT ELIGIBILITY AND ENROLLMENT ..... 4
Student Enrollment Period ..... 5
Late Enrollment ..... 5
DEPENDENT ELIGIBILITY AND ENROLLMENT ..... 5
Dependent Enrollment Period ..... 6
POLICY PERIOD AND PLAN COSTS ..... 6
PREMIUM REFUND POLICY ..... 7
Withdrawals from School ..... 7
DEFINITIONS ..... 8
PROVIDER NETWORKS ..... 10
SCHEDULE OF BENEFITS FOR SCHEDULES 1, 2, 3 ..... 10
SCHEDULE OF BENEFITS SUMMARY ..... 12
SCHEDULE OF BENEFITS PRE-CERTIFICATION REQUIREMENTS ..... 19
SCHEDULE OF BENEFITS OUT-OF-POCKET EXPENSES ..... 21
SCHEDULE OF BENEFITS FOR ADDITIONAL
INJURY AND SICKNESS COVERED EXPENSES ..... 22
Loss of Life, Limb or Sight ..... 22
Collegiate Assistance Program ..... 22
Prescription Drug Program ..... 22
CLUB SPORTS ..... 23
Catastrophic Cash Benefits ..... 24
SCHOLASTIC EMERGENCY SERVICES:
GLOBAL EMERGENCY MEDICAL ASSISTANCE ..... 25
MANDATED BENEFITS ..... 26
NOTICE OF APPEAL RIGHTS ..... 29
EXCLUSIONS AND LIMITATIONS ..... 31
Exclusions ..... 31
Limitations ..... 33
Maternity Testing ..... 33
CONTINUATION PROVISION ..... 34
SUBROGATION/RECOVERY OF BENEFITS ..... 35
EXTENSION OF BENEFITS AFTER TERMINATION ..... 35
COORDINATION OF BENEFITS ..... 35
CONFORMITY TO STATE STATUTES ..... 36
CLAIMS ADMINISTRATION AND PROCEDURES ..... 36
Explanation of Benefits ..... 36
PRIVACY POLICY ..... 36
GALLAGHER KOSTER COMPLEMENTS ..... 37
Basix Dental Savings ..... 37
CampusFit ..... 37

## INTRODUCTION

For all students, good health is essential to achieving educational goals. Maintaining good health requires access to health care when you need it. In the United States, each person is financially responsible for his or her health care, and access to health care may be affected by one's ability to pay.

Georgetown University requires students to have health insurance. We have implemented this requirement for a number of reasons:

- Because a significant percentage of our students had either no health insurance or inadequate coverage. We estimate that prior to our adopting a health insurance requirement, nearly 30 percent of our students were uninsured.
- To ensure that students have the health insurance coverage they need to secure access to health care. In the United States today, access to health care in all but life-threatening situations may be affected by those who do not have coverage.
- To help protect students from the financial burdens of an unexpected accident or illness. Our experience has shown that many students are unaware of the costs which may be incurred for diagnosis and treatment of illness and injuries. Our insurance requirement helps protect the student's educational investment.

Because so many students have difficulty obtaining comprehensive, affordable coverage on their own, the University has accepted the responsibility of obtaining an affordable plan for its students, the Premier Plan. Students who are eligible for insurance in the fall are automatically charged for the Premier Plan. Students who already have coverage of at least $300,000 per Injury and per Sickness, may waive the Premier Plan by supplying documentation of insurance coverage on a waiver form.

We use this waiver system for a very important reason - to secure a policy for students who need one in a limited period of time. Most employer-sponsored group plans deduct health insurance premiums from an employee's paycheck and enroll new employees throughout the year. Because of constant turnover in the student population, we are not able to have an extended enrollment period. The only way that we can ensure that students have insurance before the enrollment period ends on September 15, is by including the charge for insurance on the fall tuition bill of all eligible students and by requiring a waiver from those who already have coverage. Because the insurance charge is part of the tuition statement, students may use loans and scholarships to pay for it. The University has worked with Gallagher Koster to develop a health insurance policy tailored to the health needs and financial capabilities of students. UnitedHealthcare Insurance Company underwrites the Plan.

With the advent of Federal Health Care Reform/the Patient Protection & Affordable Care Act (PPACA), students may find they have many health insurance options, including remaining on their parents' insurance plan or selecting an insurance plan from their home state's insurance 'exchange'. While these options do give Georgetown Students additional choices, please make sure that any Plan you consider will provide coverage at providers on and around the Georgetown campus, and will cover you should you decide to travel domestically or internationally during your studies. Additionally, please use caution in selecting an individual or employer plan with a high deductible, as these plans can cause significant expenses for students that far exceed the premium cost of the Georgetown Premier Plan.

## ENROLLMENT PROCEDURES

### Enrollment Requirements

Georgetown University requires most students in a degree program who are registered at Georgetown University (for purposes other than enabling plan eligibility), for nine or more credit hours, registered for Thesis Research or Law and Graduate Students registered for eight or more credits to have health insurance coverage. During an enrollment period all eligible students are provided insurance information explaining the insurance requirements and enrollment/waiver procedures.

### Tuition Statement

All eligible students are charged $2,075 for insurance in the fall semester. Students who become eligible for the Plan for the first time in the spring semester are charged $1,317 for spring coverage. Upon accepting or waiving enrollment in the Plan, students should not assume that their tuition bill or student account balance includes a corresponding charge or credit for insurance.

They should verify through MyAccess, https://myaccess.georgetown.edu/ that their account has been charged or credited correctly.

## ONLINE MyAccess ENROLLMENT

The process for accepting or waiving the plan is through the student's online registration system, MyAccess. To record your insurance plan selection, log onto:
http://studentaffairs.georgetown.edu/insurance.

The online enrollment system is available through September 15, 2012, for the fall enrollment and through January 30, 2013, for the spring. Only a few students become eligible to enroll in the spring.

### If You Wish to Accept

If you do not have health insurance and wish to enroll in the Premier Plan for GU students, please log onto the website, review the health insurance information and click on "MyAccess Online Acceptance/Waiver". After August 1, and 10 business days after accepting the Premier Plan online through Georgetown University MyAccess you may print your insurance identification card from the Gallagher Koster MyAccess web site, https://www.gallagherkoster.com. After September 15, an insurance packet that includes a copy of your insurance identification card will be sent to your local address on file in the Registrar's office. You will be enrolled in the Plan and charged for insurance even if you do not submit the acceptance election. However, claim payments and prescription reimbursements for students who have not submitted an acceptance election may be delayed until October because their names will not be submitted to the claims company until late in the semester. **If you receive health care, and you have not submitted an acceptance election, submit it immediately so providers can be paid promptly for their services and your prescription card can be activated.**

### If You Wish to Waive

If you already have health insurance coverage of at least $100,000 per Injury and $100,000 per Sickness, which will remain in effect throughout the academic year, you may waive participation in the Plan by submitting documentation of other insurance. Please log onto the website, review the health insurance information, and click on "Online Acceptance/Waiver". The effective date of the other insurance must be prior to September 15, 2012, for fall waivers and, February 1, 2013, for spring waivers. The fall deadline for the submission of waivers is September 15; the spring deadline for the submission of waivers is January 31, 2013. Students who do not submit their waivers by these deadlines will be charged a $100 late fee.

***Online MyAccess Enrollment continued***

All waivers are subject to approval by the GU Student Health Insurance Office. If you are eligible in the fall and waive the insurance, you will receive on your student account a $2,075 insurance credit that applies the waiver to the entire 12-month term. If you are eligible in the spring and waive the insurance, you will receive on your student account a $1,317 insurance credit that applies the waiver to the remaining 7.5 months of the term. The checklist for Health Insurance Coverage below can assist you in determining whether your current coverage is adequate.

**Coordination Among The Offices of The Registrar, Student Accounts, and Student Insurance**

- Students are encouraged to keep their address(es) at the Registrar's office current so Covered Persons can be contacted when necessary.
- Credits for approved waivers received at least one week before registration will be posted on your student account by the registration due date.
- Checks should be made payable to Georgetown University and mailed to Georgetown University, Department 0717, Washington, DC 20073-0717. Please include your GU GoCard number on your check.

## CHECKLIST FOR HEALTH INSURANCE COVERAGE

Some students already have adequate health insurance coverage through their parent's health insurance plans, but many other students on our three campuses may lack coverage for a variety of reasons. The checklist below is designed to help students and parents evaluate the adequacy of their health insurance in relation to the special needs of students:

- Coverage in the Washington Area

Cost increases have caused many employers to adopt benefits through a health maintenance organization (HMO), preferred provider organization (PPO), or other managed care system. Some HMOs and PPOs limit access to non-emergency care to a specific geographic area. Students should have more than just emergency coverage while attending school. Adequate student coverage should provide full benefits for health care in the Washington area of no less than $100,000 per Injury and $100,000 per Sickness. For simple inexpensive tests, such as throat cultures or blood counts, HMO coverage often requires travel to an approved site.

- Club Sports Coverage

Accident coverage for club sports Injuries is provided under a separate policy, issued to Georgetown by UnitedHealthcare, 2012-32-8. The club sports plan does cover specific GU club sports injuries. Refer page 23 for more detail.

- Study Abroad and Worldwide Coverage

This policy provides worldwide coverage. Georgetown University students in Study Abroad programs have an additional overseas policy to cover medical treatment rendered outside of the United States. The Study Abroad overseas policy will not be accepted as the only "other insurance" for purposes of meeting the waiver requirement to decline this plan. Because the additional overseas policy enhances this Policy's overseas coverage, students are encouraged to maintain enrollment in both plans.

***Checklist for Health Insurance Coverage continued***

▪ Mental Health Care Benefits

Employer-sponsored group health insurance programs often provide mental health care benefits at the state-mandated level, which may be insufficient for the needs of a student. Your health insurance program should provide a level of benefits for mental health care comparable to the coverage provided by the Premier Plan.

▪ Insured's Payment Obligations

The Georgetown University Student Health Center (SHC) charges students for visits. Parents and students should make certain that their deductibles and coinsurance would not preclude them from obtaining appropriate health care services. A description of our plan's deductible and other payment obligations is included in the Schedule of Benefits Summary on page 12-18.

▪ Full-Time / Part -Time

If you qualify as a dependent on your parent's plan because you are a full-time student in the fall, then reduce credit hours in the spring semester to part-time and are disqualified from your parent's plan, you may also be disqualified to enroll in the plan offered by the University. If your other coverage will terminate in the spring due to reduced credit hours, consider accepting the plan in the fall, for 12 months of coverage, instead of waiving it.

▪ Dual Coverage Under This Plan and Another Plan

You may want to remain covered under your current plan and purchase this Plan. However, this Plan would not necessarily be your primary plan. This Plan coordinates benefits with other plans to determine which plan pays first. Refer to the Coordination of Benefits explanation on page 35, if you wish to be covered under this Plan and another.

## STUDENT ELIGIBILITY AND ENROLLMENT

Coverage is available to most students in a degree program who are registered at Georgetown University (for purposes other than enabling plan eligibility) for nine or more credit hours, or for Thesis Research, or Law and Graduate Students registered for eight or more credit hours and are actively attending classes or completing other required academic work. Special Academic Program groups are also designated by the Office of Student Health Insurance as eligible and are required to have health insurance including Ophthalmology Assistant Trainees within the Department of Ophthalmology.

Students who are enrolled for less than nine credit hours (eight credit hours for law and graduate students) are not eligible for coverage under this Plan except for:

- Students who were enrolled in the health plan for GU students (whose coverage expired August 15, 2012), who are enrolled in a degree program, and who have reduced their credit hours to part-time (less than nine) due to sickness or injury.
- Students who were enrolled in the health plan for GU students (whose coverage expired August 15, 2012), and who have been granted a medical leave of absence.

A medical release from the Director of The Counseling and Psychiatric Service or the Director of The Student Health Center must affirm the medical necessity of a reduction in hours or medical leave of absence, and a letter from the applicable academic Dean authorizing the request, must be submitted to the GU Student Health Insurance Office.

***Student Eligibility and Enrollment continued***

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

### Student Enrollment Period

Coverage must be purchased at the beginning of each Plan year. Students enrolling in the new Plan year will have continuous coverage if they enroll and pay the premium during the prescribed enrollment period. The enrollment period for the 2012-2013 Plan year begins July 1, 2012, and ends September 15, 2012. Eligible students who enroll during this enrollment period will be covered from August 15, 2012, through August 14, 2013.

Eligible students who wish to enroll in the Plan for the first time or who are returning after a break in enrollment must enroll during the fall enrollment period. Students who are not eligible to enroll in the fall, but are eligible to enroll in the spring, may enroll during the spring enrollment period which begins December 1, 2012, and ends January 31, 2013. The coverage period for such students will become effective on January 1, 2012, and will remain in effect through August 14, 2013. If a student does not enroll within these required time periods, the student must wait to enroll until the next enrollment period (subject to the Late Enrollment provisions described below).

### Late Enrollment

Eligible students or dependents will not be allowed to enroll in the Plan after the applicable enrollment period unless proof is furnished that the eligible student or dependent became involuntarily ineligible due to age or employment status for coverage under another group health insurance plan during the 31 days preceding the date of the request for late enrollment. The effective date of coverage will be the day after the involuntary termination date. Students must submit an acceptance election and documented proof of notification of involuntary ineligibility. Eligible students who wish to enroll themselves or their dependents after the applicable enrollment period should contact the GU Student Health Insurance Office (202-687-4883) upon receiving notification of involuntary ineligibility.

## DEPENDENT ELIGIBILITY AND ENROLLMENT

Eligible students who enroll may also insure their dependents. Eligible dependents are the legal spouse, regardless of gender, the Named Insured's partner in a recognized, legal marriage entered into in another jurisdiction that is not expressly prohibited or deemed illegal in the District, and unmarried children by blood or by law under 26 years of age who are not self-supporting. Dependent eligibility expires concurrently with that of the insured student. No one will be eligible as a dependent while covered as a student (a student cannot be covered twice under the Plan) or while in active military service. A child who is physically or mentally incapable of self-support upon attaining age 19 may continue under the Plan as long as he or she remains incapacitated and unmarried and the student's own coverage continues. UnitedHealthcare Insurance Company may request proof of incapacity from time to time.

*Dependent Eligibility and Enrollment continued*

### Dependent Enrollment Period

Students who are enrolled in the Plan may enroll eligible dependents. Students who wish to enroll eligible dependents must enroll them and pay the required premium within the enrollment periods stated in the previous section or within 31 calendar days of one of the following qualifying events: acquiring a new dependent through birth, adoption, legal guardianship, primary care (Primary care means that the Insured provides food, clothing, and shelter, on a regular and continuous basis, for the minor grandchild, niece or nephew during the time that the District of Columbia public schools are in regular session), or marriage or after a dependent is involuntarily terminated under another health plan (see Late Enrollment).

The date of the dependent's coverage will be:

- the effective date of the student's coverage, if the dependent enrolls during the eligible enrollment period, or
- the date of qualifying event, if the dependent enrolls within 31 calendar days of the qualifying event.

In the event of the birth of a child to a student while the student's Plan is in force, the child will automatically become a Covered Person from the moment of birth. Coverage will continue without cost for 31 days. If the student has no other covered children, payment for the child's coverage must be remitted within that 31 day period, or the coverage will terminate for that child at the end of the 31 day period. If the student has other covered children, no additional payment is necessary, but the newborn must be officially enrolled within the 31 day period. The student should contact the GU Student Health Insurance Office (202-687-4883) promptly after the birth of the newborn to obtain the forms necessary to enroll a newborn.

Change in Family Status Notification

Students with enrolled dependents must notify the GU Student Health Insurance Office (202-687-4883) whenever they change from one to another of the following classifications: 1) eligible spouse only, 2) eligible spouse and children, or 3) eligible children only.

## POLICY PERIOD AND PLAN COSTS

The Master Policy on file at Georgetown University becomes effective at 12:01 a.m. on August 15, 2012 and terminates at 11:59 p.m. on August 14, 2013. Coverage will be in effect on August 15, 2012 at 12:01 a.m. through August 14, 2013 at 11:59 p.m. for students who enroll during the fall enrollment period. For students who enroll in the spring, coverage will become effective on January 1, 2013 at 12:01 a.m. through August 14, 2013 at 11:59 p.m.

| | Annual* | Spring Semester* |
|---|---|---|
| Student Only | $ 2,075.00 | $ 1,317.00 |
| Student & Spouse | $ 6,063.00 | $ 3,787.00 |
| Student & All children | $ 6,063.00 | $ 3,787.00 |
| Family | $ 9,547.00 | $ 5,945.00 |

* Includes a $77 Georgetown University Administrative Fee.

This is a non-renewable one year term policy.

## PREMIUM REFUND POLICY

Students who withdraw from the University for non-medical reasons during the first 31 days of the semester are not eligible for the Plan. Students must notify the GU Student Health Insurance Office (202-687-4883) of such withdrawal and the entire cost of the coverage for that enrollment period (including dependent coverage) will be credited to the student's account. Such a student will not be entitled to any benefits during the days described above and no claims received will be honored. Partial refunds of premium are allowed only upon entry into the armed forces.

The Plan for students and dependents will terminate on August 14, 2013. Any Covered Person who is called into active duty into the armed forces of any country will be terminated from the Plan and will receive a pro-rated refund upon notifying the GU Student Health Insurance Office.

### Withdrawals from School

In the event that an otherwise eligible student withdraws from the University within thirty-one (31) calendar days beginning with the first day of regularly scheduled classes, one of three of the following may take place:

1. If an unexpected Sickness or Injury occurs within the first 31 days forcing the student to withdraw from classes; and a medical leave of absence is granted by the Dean, he or she may be covered for the remainder of the Plan year. In this case, a medical release must be granted by the Medical Director of either The Student Health Center (SHC) or Counseling and Psychiatric Service (CAPS). Students who intend to pursue this option should contact the appropriate Medical Director within this 31-day period. If the student wishes to terminate his or her coverage, a full refund will be issued upon notifying the GU Student Health Insurance Office, provided no claims have been submitted.
2. If a student, who was enrolled in the prior GU Plan (whose coverage expired August 15, 2012), is forced by Sickness or Injury to withdraw from classes and for whom a medical leave of absence is granted by the Dean, may be covered under this Plan. In this case, a medical release must be granted by the Medical Director of either the SHC or CAPS. Students who intend to pursue this option should contact the appropriate Medical Director within this 31 day period and must also contact the GU Student Health Insurance Office for enrollment instructions. Contact the Student Health Insurance Office regarding the terms and conditions on medical leave of absence.
3. Students who withdraw from the University for non-medical reasons, or who are not granted a medical leave of absence during the first 31 days of the semester, are not eligible for the Plan. Students must notify the GU Student Health Insurance Office (202-687-4883) of such withdrawal and the entire cost of the coverage for that enrollment period (including dependent coverage) will be credited to the student's account. Such a student will not be entitled to any benefits from the 2012-2013 GU Student Health Insurance Plan and no claims will be honored.

Students who withdraw from the University for any reason after the first 31 days of the semester will remain covered under the Plan for the full term and will be obligated to pay the premium and no refund will be made available.

A student who is covered in the fall semester and withdraws from the University in the spring semester shall not be entitled to receive any refund.

## 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 Medical Expenses.

**Covered Medical Expenses or Covered 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 6) in excess of the amount stated as a Deductible.

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 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 Per Policy Year.

**Hospital** means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home. Hospital also means a licensed alcohol and drug abuse rehabilitation facility and a mental hospital. Alcohol rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises or on a prearranged basis.

**Hospital Confined/Hospital Confinement** means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

**Injury** means bodily injury which is: 1) directly and independently caused by contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; and 3) a source of loss. 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.

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

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

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

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

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

**Medical Necessity** means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

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

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

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

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

The fact that a Physician may prescribe, authorize or direct a service does not of itself make it medically necessary or covered by this Policy.

**Mental Illness** means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases.* The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases does not mean that treatment of the disorder is a Covered Medical Expense.*

**Physician** means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

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

**Physiotherapy** means any form of the following: physical or mechanical therapy; diathermy; ultrasonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

**Policy Year** means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

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

**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.

**Skilled Nursing Facility** means a Hospital or nursing facility that is licensed and operated as required by law.

**Substance Use Disorder** means a Sickness that is listed as an alcoholism and substance use disorder *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases.* The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases does not mean that treatment of the disorder is a Covered Medical Expense*

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

**We, Us, Ours** means the UnitedHealthcare Insurance Company or its authorized agent.

## PROVIDER NETWORKS

Enrollees will minimize their out-of-pocket expenses by going to providers, as follows:

- First, as availability permits, to the Student Health Center (SHC) or Counseling and Psychiatric Service (CAPS);
- Second, to the Georgetown University Hospital and/or UnitedHealthcare Options PPO Network in the DC area and across the country; and,
- Third, to all other providers.

At the Student Health Center (SHC) most basic services for the treatment of Sickness and Injury are provided to students who are actively attending classes. These services are paid in full, subject to a minimal Co-payment under Schedule 1. Students requiring special services, which cannot be provided by the SHC, may go to Preferred Providers. Covered Expenses for Preferred Providers are subject to a policy year Deductible, require a Co-payment for Outpatient Physician visits, and are then paid at 80%, unless specified otherwise, under Schedule 2.

At the Counseling and Psychiatric Service (CAPS), evaluations and referral services are free for students. CAPS charges fees for extended psychotherapy and treatment following completion of an evaluation. Fees are reasonable, but availability for treatment services is limited. Spouses and dependents who are not students are not eligible for services at CAPS. Part-time students, including thesis-research students enrolled for less than 9 credits, are eligible for evaluation and referral services only.

To locate a UnitedHealthcare Options PPO Network provider call 1-877-935-5437.

### Preferred Providers

Preferred Providers are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices or a Preferred Allowance. Preferred Providers will accept the Preferred Allowance as payment for Covered Expenses. Preferred Providers in the Georgetown University area are: Student Health Center (SHC), Counseling and Psychiatric Services (CAPS); Georgetown University Hospital (GUH), and participating members of the UnitedHealthcare Options PPO Network.

When your Physician needs to order services from other providers, such as lab work, radiology services, supplies or appliances, you should remind him or her that your plan has limited benefits for Out-of-Network care and services. Most services that are provided by Schedule 2 providers are subject to a $200 per Policy Year Deductible, or a $250 per Policy Year Deductible for Schedule 3 providers, even when ordered by Schedule 1 Physicians.

The Covered Person should be aware that Preferred Provider Hospitals might be staffed with Out-of-Network providers. As a result, receiving services or care from an Out-of-Network provider at a Preferred Provider Hospital does not guarantee that all charges will be paid at the Preferred Provider level of benefits.

## SCHEDULE OF BENEFITS FOR SCHEDULES 1, 2, 3

If an Insured Person requires treatment by a Physician, we will pay the Usual and Customary Charges incurred for Medically Necessary Covered Expenses, as shown in the Schedule of Benefits.

Benefit payments are determined based on where services are provided and who provides the service. Schedules 1, 2 and 3 are available to all students who enroll in the Plan. Schedules 2 and 3 are available to all dependents who enroll in the Plan. Generally, out-of-pocket expenses are lowest when you access providers under Schedule 1-first; 2-second and 3-third. The Schedule of Benefits Summary on pages 12-18 sets forth the benefits available under each of these schedules.

## Schedule 1

Covered Expenses under Schedule I are provided by the Student Health Center (SHC) and the Counseling and Psychiatric Service (CAPS). Provider availability is subject to change. For most Schedule 1 services, the Deductible is waived, the Co-payments are less, and the Plan pays 100% of the Preferred Allowance.

**Special SHC Benefits**

Treatment of corns, calluses, bunions, hirsutism, alopecia, and TB testing are Covered Expenses only when provided at the SHC. A $15 per visit Co-payment applies.

Referrals Required for Other Special Benefits

Each Injury or Sickness is a separate condition and a separate referral is required for each condition each policy year.

SHC referrals are required for the following special benefits:

- Nutritional counseling by a Georgetown University Health Education certified nutritionist to be paid at 100% of Preferred Allowance;
- Outpatient Physical Therapy; benefits are paid at 80% of Preferred Allowance after the Deductible is applied (Schedule 2); and 70% of the Usual and Customary Charges after the Deductible is applied (Schedule 3) for 2 visits/week with a 6 week maximum when referred by the SHC or the GUH Orthopedic Department; Limited to one visit per day. Please refer to page 13 for additional Physical Therapy benefits associated with Surgery and Hospital Confinement.
- Sleep disorders to be paid as any other Sickness, at 80% of Preferred Allowance after the Deductible and Co-payment are applied (Schedule 2); and 70% of the Usual and Customary Charge after the Deductible is applied (Schedule 3); and
- Allergy testing and treatment requires an SHC referral and pre-certification by AdvoCare. After the Deductible, the Preferred Provider reimbursement is 70% of the Preferred Allowance; the Out-of-Network reimbursement is 60% of Usual and Customary Charge. any follow-up visits to testing will be paid as a specialist under Schedules 2 & 3.

If you can't obtain an SHC referral due to inaccessibility, please email Studentinsurance@gallagherkoster.com.

**The following benefit will be covered with a referral from the designated Georgetown Learning Disability Coordinator:**

- Psychological testing to determine learning disabilities, paid at 100% of Preferred Allowance under Schedule 1; 80% of Preferred Allowance under Schedule 2; and 70% of Usual and Customary Charges under Schedule 3. (policy Deductible does not apply).

## Schedule 2

Covered Expenses are available under Schedule 2 through Georgetown University Hospital (GUH) or the UnitedHealthcare Options PPO Network. For most Schedule 2 Services, after the $200 per Policy Year Deductible and Co-payment per visit are applied, the Plan pays 80% of the Preferred Allowance.

## Schedule 3

Covered Expenses are available under Schedule 3 through Out-of Network Providers. For most Schedule 3 services, the Deductible is applied then the Plan pays 70% of the Usual and Customary Charge (U&C). Enrollees are responsible to pay 30% of the U&C, and any charges in excess of the Covered Expense. Out-of-Network providers have not agreed to accept a predetermined fee schedule. Therefore, Covered Persons may incur significant out-of-pocket expenses in excess of the Covered Expense with Out-of-Network providers.

# SCHEDULE OF BENEFITS SUMMARY

**PA = Preferred Allowance** **U&C = Usual & Customary Charges**

**Usual & Customary Charges will be calculated based on the 80th percentile of FAIR Health, Inc.**

| | Schedule 1<br>SHC & CAPS | Schedule 2<br>GUH & UHC PPO Network | Schedule 3<br>Out-of-Network & Out of Country |
|---|---|---|---|
| **Provider Network** | Student Health Center (SHC) and Counseling & Psychiatric Care Service (CAPS). Subject to Availability | Preferred Providers: Georgetown University Hospital (GUH), UnitedHealthcare Options PPO Network | Out-of-Network Providers, including Out of Country Providers |
| **Deductible per Policy Year** | No Deductible | $200 per Student* / $600 per Family* | $250 per Student* / $600 per Family* |
| **Combined Maximum Benefit:** For all schedules per Injury or Sickness. | $300,000 | | |
| **OUTPATIENT EXPENSES** | | | |
| **Physician Visit Expense:** Benefits for Physician's Visits do not apply when related to same day surgery and Physiotherapy.<br>(Benefits include surgery when performed in the Physician's office for Schedules 1 and 2) | 100% of PA; $10 Copay for special SHC benefits | 100% of PA; $10 Copay office visit; $20 Copay, Specialist visit; | 70% of U&C* |
| **Day Surgery Miscellaneous Expense:** In conjunction with scheduled surgery performed in a Hospital. Includes operating room expense, laboratory tests & diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines, & Supplies. Usual and Customary charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility charge Index. | Not Available | 80% of PA* | 70% of U&C* |

| OUTPATIENT EXPENSES | Schedule 1<br>SHC & CAPS | Schedule 2<br>GUH & UHC PPO Network | Schedule 3<br>Out-of-Network & Out of Country |
|---|---|---|---|
| **Surgeon and Assistant Surgeon's Fees Expense:** For limitations on multiple surgeries, see page 34. | Not Available | 80% of PA* | 70% of U&C* |
| **Anesthetist Expense,** professional services administered in connection to surgery. | Not Available | 80% of PA* | 70% of U&C* |
| **Physiotherapy (Physical Therapy)** for a condition that required surgery or Hospital Confinement, within the 30 days after the surgery or release from the Hospital or within the 30 days following the attending Physician's release for rehabilitation.<br>Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative therapy. See also Benefits for Habilitative Services for Treatment of Congenital or Genetic Birth Defects.<br>Limited to one visit per day. | Not Available | 80% of PA* | 70% of U& C* |
| **Physiotherapy (Physical Therapy) Other**, with referral from SHC or the GUH Orthopedic Department.<br>Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative therapy. See also Benefits for Habilitative Services for Treatment of Congenital or Genetic Birth Defects.<br>Limited to one visit per day. | Not Available | 80% of PA* | 70% of U&C* |
| **Diagnostic X-ray & Laboratory Services** | 100% of PA when billed by SHC. Available services are limited. | 80% of PA* | 70% of U&C* |
| **Test & Procedures Expense:** Includes 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. | 100% of PA when billed by SHC. Available services are limited. | 80% of PA* | 70% of U&C* |

| OUTPATIENT Continued | Schedule 1<br>SHC & CAPS | Schedule 2<br>GUH & UHC PPO Network | Schedule 3<br>Out-of-Network & Out of Country |
|---|---|---|---|
| **Medical Emergency Expense:** The Copayment is waived if hospitalized. Includes attending Physician's charges, surgery, x-rays, laboratory procedures, injections, testing and facility charge for the use of the emergency room and supplies. | Not Available | After a $100 copay & applicable Deductible, 100% of PA* | After a $100 copay & applicable Deductible 100% of U&C* |
| **Injections,** when administered in the Physician's office and charged on the Physician's statement. | 100% of PA | 80% of PA* | 70% of U&C* |
| **Radiation & Chemotherapy Expenses** | Not Available | 80% of PA* | 70% of U&C* |
| **INPATIENT** | | | |
| **INPATIENT EXPENSES (Precertification Required for Inpatient Admissions)** | | | |
| **Physician Visit Expense:** non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery. | 100% of PA* | 80% of PA* | 70% of U&C* |
| **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. See Benefits for Postpartum Care. | 100% of PA* | 80% of PA* | 70% of U&C* |
| **Surgeon and Assistant Surgeon's Fees Expense:** for limitations on multiple surgeries, see page 34. | Not Available | 80% of PA* | 70% of U&C* |
| **Anesthetist Expense,** professional services administered in connection to surgery. | Not Available | 80% of PA* | 70% of U&C* |
| **Pre-admission Testing Expense:** This benefit is payable within 3 days prior to admission. | Not Available | 80% of PA* | 70% of U&C* |
| **Hospital Expense:** Includes daily semi-private room rate when confined as an Inpatient; general nursing care provided by the Hospital. Hospital Miscellaneous Expenses include the cost of the operating room, laboratory test, x-ray examinations, anesthesia, drugs (excluding take home), medicines, therapeutic services, or supplies. | Not Available | 80% of PA* | 70% of U&C* |

| INPATIENT Continued | Schedule 1<br>SHC & CAPS | Schedule 2<br>GUH & UHC PPO Network | Schedule 3<br>Out-of-Network & Out of Country |
|---|---|---|---|
| **Registered Nurse Expense,** private duty nursing care. | Not Available | 80% of PA* | 70% of U&C* |
| **Intensive Care Unit/Hospital Expense** | Not Available | 80% of PA* | 70% of U&C* |
| **Skilled Nursing Facility,** services received while confined as a full-time Inpatient in a licensed Skilled Nursing Facility in lieu of or within 24 hours following a Hospital Confinement. | Not Available | 80% of PA* | 70% of U&C* |
| **Physiotherapy (Physical Therapy)** | Not Available | 80% of PA* | 70% of U&C* |
| | | | |
| **Allergy Testing:** Please refer to Exclusion #1. SHC referral and AdvoCare precertification required. Any follow-up visits to testing will be paid under Physician's Visits as a Specialist. | Not Available | 70% of PA* | 60% of U&C* |
| **Ambulance Services** | Not Available | 80% of PA* | 70% of U& C* |
| **Durable Medical Equipment,** a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. | Not Available | 80% of PA* | 70% of U&C* |
| **Consultant Physician Fees:** When requested by attending Physician. Includes services rendered by GU Health Education Certified Nutritionist to be paid at 100% of PA. | Not Available | 80% of U&C* | 70% of U&C* |
| **Dental Treatment:** Treatment to sound, natural teeth when made necessary by injury.<br>*(Benefits are not subject to the $300,000 Maximum Benefit.)* | Not Available | 80% of U&C* | 80% of U&C* |

| OTHER | Schedule 1<br>SHC & CAPS | Schedule 2<br>GUH & UHC PPO Network | Schedule 3<br>Out-of-Network & Out of Country |
|---|---|---|---|
| **Complications to Non-Covered Services** | $10 copay, 100% of PA | 80% of PA* | 70% of U&C* |
| **Maternity,** See Benefits for Postpartum Care. | Not Available | Paid as any other Sickness | |
| **Complications of Pregnancy:** | Not Available | Paid as any other Sickness | |
| **Home Health Care:** services rendered from a licensed home health care agency that are ordered by a Physician, provided or supervised by a Registered Nurse in the Insured Person's home, and pursuant to a home health plan.<br>Includes maximum of 90 days per Policy Year. | Not Available | 80% of PA* | 70% of U&C* |
| **Hospice Care:** services received from a licensed hospice agency and when recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less.<br>(Hospice Care benefits are not subject to the $300,000 Maximum Benefit.)<br>The policy deductible does not apply. | Not Available | 80% of PA* | 70% of U&C* |
| **Speech Therapy:** Includes maximum of 20 visits per Policy year. | Not Available | 80% of PA* | 70% of U&C* |
| **Prescription Drugs:** | Not Available | Prescriptions must be filled at a UnitedHealthcare Network Pharmacy. $10 copay for up to 31 day supply of a Tier 1 prescription; $25 copay up to 31 day supply of a Tier 2 prescription; or $45 copay up to 31 day supply of a Tier 3 prescription | |
| **Learning Disability Testing:** Services only provided for testing when referred by the designated Georgetown Learning Disability Coordinator. | Not Available | 80% of PA | 70% of U&C |

| OTHER Continued | Schedule 1<br>SHC & CAPS | Schedule 2<br>GUH & UHC PPO Network | Schedule 3<br>Out-of-Network & Out of Country |
|---|---|---|---|
| **Diabetes Services:** See Benefits for Diabetes. | Paid as any other Sickness | | |
| **Reconstructive Breast Surgery Following Mastectomy:** in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas. | Paid as any other Sickness | | |
| **Mental Illness Treatment:** see Benefits for Mental Illness and Substance Use Disorders.<br>*Limited to one visit per day except when a medication management visit or partial hospital / facility confinement is necessary.* | Paid as any other Sickness | | |
| **Substance Use Disorder Treatment:** see Benefits for Mental Illness and Substance Use Disorders. | Paid as any other Sickness | | |
| **Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder:**<br>(TMJ and Craniomandibular Disorder benefits are not subject to the $300,000 Maximum Benefit.) | Paid as any other Sickness | | |

| OTHER Continued | Schedule 1<br>SHC & CAPS | Schedule 2<br>GUH & UHC PPO Network | Schedule 3<br>Out-of-Network & Out of Country |
|---|---|---|---|
| **Preventive Care Services,** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.<br><br>Preventive Care Services which include, but are not limited to, annual physicals, GYN exams, routine screenings and immunizations are covered at 100% with no copay or deductible only when the services are received from a Preferred Provider. Please see www.healthcare.gov for complete details of the services provided for specific age and risk groups.<br><br>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. | 100% of PA | 100% of PA* | No Benefits |

**NOTICE TO PLAN PARTICIPANTS**

The organization that sponsors your student health insurance coverage has certified that it qualifies for a temporary enforcement safe harbor with respect to the Federal requirement to cover contraceptive services without cost sharing. During this one-year period, coverage under your student health insurance coverage will not include coverage of contraceptive services.

* Deductible Applies

** When a Doctor orders services such as lab work, radiology services, supplies or appliances, remind the doctor that your plan has limited benefits for out of network care and services as identified in Schedule 3.

## SCHEDULE OF BENEFITS PRE-CERTIFICATION REQUIREMENTS

**Pre-Admission Certification for Hospital Admissions**

Pre-Admission Certification must be obtained for every Hospital Admission. Please refer to the subsequent sections on Pre-Certification provisions for Maternity and Medical Emergency admissions. These admissions have separate certification requirements.

Insured Persons are responsible for obtaining Pre-Admission Certification and are responsible for informing the Hospital or other Physician that their insurance plans require Pre-Admission Certification.

To obtain Pre-Admission Certification:

1) AdvoCare must be provided with necessary information to make decisions regarding the Medical Necessity of admission; and
2) AdvoCare must be contacted no less than forty-eight (48) hours prior to Hospital admissions. This does not apply to Medical Emergency admissions. Refer to the following section for descriptions of the certification provisions for this type of admission. Notice may be given to AdvoCare by the Hospital, admitting Physicians, Insured Persons, or family members of Insured Persons.

Notice may be given by calling AdvoCare at (800) 525-8548.

The following information is requested by AdvoCare in order to evaluate planned Hospital admissions:

- Name, Insurance ID number, and age of patient;
- Student's name, Insurance ID number, and name of the university;
- Scheduled dates of admissions; and
- Names and telephone numbers of admitting Physicians and Hospitals.

When Pre-Admission Certification is provided to Insured Persons, a standard number of Inpatient Hospital days for the stays are assigned. If AdvoCare is not informed of admissions within the required period of time, payment of benefits for admitting Physicians' and Hospitals' charges are reduced by 50%. This is referred to as a "penalty". This penalty will not be applied toward any Deductibles, Coinsurance or Out-of-Pocket Maximum. It is not necessary to pre-certify Hospital admissions that occur outside of the United States.

**Pre-Certification for Allergy Testing**

In rare cases, allergy testing is a medical necessity. In order to limit allergy testing coverage to only medically necessary cases, pre-certification must be obtained by AdvoCare for coverage. To obtain pre-certification, the Student Health Center (SHC) must submit documentation to AdvoCare of adherence to the AdvoCare allergy treatment protocol. Additionally, an SHC referral must accompany any claim submitted for allergy testing.

**Certification of Medical Emergency Admissions**

If an Insured Person is admitted to a Hospital for Medical Emergency admission, notice of admission must be provided to AdvoCare no later than one (1) day following the date of admission. Notice may be given to AdvoCare by the Hospital, admitting Physician, Insured Person, or family members of Insured Person.

Notice may be given by calling AdvoCare at (800) 525-8548.

AdvoCare reviews cases within one (1) working day of the date they are informed of the admission. The reviews are performed with Insured Person's Physician or designated staff to determine if continued Hospital stays are Medically Necessary. If AdvoCare is not informed of Medical Emergencies within the required period of time, payments for admitting Physician and Hospital charges are reduced by 50%. This is referred to as a "penalty". This penalty will not be applied toward any Deductibles, Coinsurance or the Out-of-Pocket Maximum.

Medical Emergency admissions are defined as admissions to a Hospital through the emergency rooms of those facilities for treatment of a Medical Emergency. Medical Emergency admissions are unplanned admissions scheduled less than forty-eight (48) hours prior to the admission, for treatment of a Medical Emergency. It is not necessary to pre-certify Hospital admissions that occur outside the United States.

**Certification of Maternity Admissions**

Maternity admissions are admissions to Hospitals expressly for giving birth. An anticipated maternity admission must be reported to AdvoCare during the first three (3) months of the pregnancy to ensure that a high risk screening evaluation will be done. When an Insured Person is actually admitted to a Hospital for the express purpose of giving birth, AdvoCare should be notified of the admission no later than one (1) day following the admission date. Notice may be given to AdvoCare by the Hospital, admitting Physician, Insured Person or family members of the Insured Person.

Notice may be given by calling AdvoCare at (800) 525-8548.

If the admission and discharge dates are the same or if the Insured Person is discharged on the day following the admission date, it is not necessary to notify AdvoCare of the maternity admission following the admission date.

**Additional Hospitalization Reviews**

Additional Hospitalization reviews include:

1) During an Insured Person's Hospital stay, AdvoCare continues to review the Hospital stay. This does not apply to maternity admissions except if the stay is greater than two days. The purpose of continued reviews is to obtain updates as to an Insured Person's progress and, if necessary, to enable AdvoCare to reevaluate the Medical Necessity of a continued Hospital stay.
2) All weekend (Friday and Saturday) Hospital admissions are reviewed. Coverage is limited to Medically Necessary admissions.

Review for discharge planning is also conducted. Discharge planning identifies patients who require extended care following a discharge. Discharge planning also determines the most appropriate setting for continued care.

## SCHEDULE OF BENEFITS OUT-OF-POCKET EXPENSES

### Maximum Benefits

The Policy provides medical benefits for Covered Medical Expenses incurred by a Covered Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $300,000 for each Injury or Sickness per Policy Year.

### The Deductible

The Deductible is the amount you pay each Plan year for certain Covered Expenses before the Plan will pay any further expenses. It applies to any individual covered by the Plan. You satisfy the Deductible just once each Plan year, even if you have several different kinds of expenses. Coinsurance and Co-payments count toward the Deductible under any schedule. See the Schedule of Benefits Summary on pages 12-18.

There is no Deductible for coverage under Schedule 1. The Deductible under Schedule 2 is $200 per person not to exceed $600 per family per Plan year and the Deductible under Schedule 3 is $250 per person not to exceed $600 per family per Plan year. All Covered Medical Expenses applied to the Deductible will be used to satisfy both the Preferred Provider and the Out-of-Network Deductible.

Charges incurred and applied to the Deductible during the period from June 1 up to the commencement of the Plan year on August 15 of that year will be applied against the upcoming Plan year Deductible, and thus, will reduce or eliminate the upcoming Plan year Deductible.

### The Copayments

A Copayment is a fixed dollar amount that you must pay each time you receive certain Covered Expenses as indicated in the Schedule of Benefits Summary on pages 12-18. For example, Physician visits, Emergency Room visits, and Prescriptions have Copayments.

### Coinsurance

Coinsurance is a fixed percentage of Covered Expenses that the Plan pays, after you have met the applicable Deductible. The percentage amount depends upon the type of service and the Schedule under which you have received covered services. For example, the Schedule 2 coinsurance of 80% and Schedule 3 coinsurance of 70% generally represents the amount the Plan will pay.

### Limits on Your Out-of-Pocket Expenses

The maximum Out-of-Pocket medical expense is $5,000 per individual and $10,000 per family per Plan year. The Deductible, Copayments, and Coinsurance incurred under any Schedule are applied to the Out-of-Pocket limitation, except for prescription Copays that are not applied to your Out-of-Pocket maximum. Charges in excess of U&C, and any additional prescription expense, do not apply towards the Out-of-Pocket maximum.

## SCHEDULE OF BENEFITS FOR ADDITIONAL INJURY AND SICKNESS COVERED EXPENSES

### Accidental Death & Dismemberment

### Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 365 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 | $2,500 |
| One Member | $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.

### Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing 1-877-643-5130. 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.

### Prescription Drug Program

UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits (up to 31 days) and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are a certain Prescription Drugs that require your Physician to notify us to verify their coverage 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 or call 1-877-417-7345 for the most up-to-date tier status.

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

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

$45 per prescription order or refill for a Tier 3 Prescription Drug

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

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

If you do not present the card, you will need to pay 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, to enroll in mail order, or for information about network pharmacies, please visit www.uhcsr.com and log in to your online account or call 1-877-417-7345.

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

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

Definitions

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

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

## CLUB SPORTS

▪ Club Sports Coverage

Accident coverage for club sports Injuries are covered under a separate policy, 2012-32-8 issued to Georgetown University and underwritten by UnitedHealthcare Insurance Company. After the benefits covered under 2012-32-8 have been paid, AIG will cover injuries sustained while participating in the following GU club sports: soccer, lacrosse, rugby, softball, water polo, volleyball, field hockey, ice hockey, ultimate frisbee, triathlon, racquetball, squash, baseball, basketball, tennis, cycling, running, boxing, equestrian, fencing and student trainers/managers according to the policy terms and limitations as described under the AIG Catastrophic Club Sports Policy. The AIG policy will pay up to $5 million dollars of covered expenses incurred within five years of the injury. Neither UnitedHealthcare Insurance Company nor AIG covers injuries sustained while participating in intercollegiate or professional sports, see Exclusion 15

## Catastrophic Cash Benefits

The Catastrophic Cash Benefits plan is not underwritten by UnitedHealthcare Insurance Company.

If injury to the Insured results, within 365 days of the date of the accident that caused the Injury, in Paralysis or Coma, the Company will pay a benefit under the conditions described below. In order for a benefit to be payable under this policy, the Paralysis or Coma must continue for a Waiting Period of 12 consecutive months, must be determined by a Physician to be permanent and irreversible at the end of that Waiting Period and must result in Disability. The benefit payable is based on the percentage of the Initial Lump Sum Maximum Amount shown below for the causes of Disability shown below.

| Cause of Disability | Percentage of Initial Lump Sum Maximum Amount |
|---|---|
| Coma | 100% |
| Paralysis of Two or More Limbs (Upper and/or Lower) | 100% |
| Paralysis of One Limb (Upper or Lower) | 50% |
| Paralysis of One or More Other Parts of the Body | See NOTE below |

NOTE: If the Insured's Paralysis is a part of the body other than a Limb, the percentage of the Maximum Amount used to determine the benefit payable will be adjusted in proportion to the comparable extent of Paralysis of the listed parts of the body. The final determination of comparable extent will be made through the use of the most current edition of the "Guides to the Evaluation of Permanent Impairment" published by the American Medical Association. (In the event the referenced guide ceases to be published, the Company will select another appropriate measurement of impairment values.)

If the insured suffers more than one cause of disability as a result of the same accident, only one Percentage of the Maximum Amount, the largest for any one cause of Disability suffered by the Insured, will be used to determine the benefit payable.

The benefit payable for $3,000,000 is:

**LUMP SUM:** Payable at the end of the Waiting Period. $1,000,000 Lump Sum, then $75,000 per year for 30 years.

Periods of Disability separated by less than 30 consecutive days will be considered one period of disability unless due to separate and unrelated causes.

The Company reserves the right, at the end of the Waiting Period (and as often as it may reasonably require thereafter) to determine, on the basis of all the facts and circumstances, that the Insured is Disabled due to the Paralysis or Coma, including, but not limited to, requiring an independent medical examination at the expense of the Company.

**Coma:** as used in this policy, means a profound state of unconsciousness from which the Insured cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.

**Disabled/Disability:** as used in this policy, means that the Insured is unable while under the regular care of a Physician, to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the insured immediately prior to the accident.

**Limb:** as used in this policy, means entire arm or entire leg.

**Paralysis:** as used in this policy, means the complete loss function in a part of the body as a result of neurological damage as determined by a Physician.

This plan is underwritten by AIG.

## SCHOLASTIC EMERGENCY SERVICES: GLOBAL EMERGENCY MEDICAL ASSISTANCE

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

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

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

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

Please visit www.gallagherkoster.com or your school's insurance coverage page at 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.

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 for additional information, including limitations and exclusions pertaining to the SES program.

## MANDATED BENEFITS

### *Benefits for Mental Illness and Substance Abuse*

Benefits will be paid the same as any other Sickness for the treatment of Mental Illness and Substance Use Disorders subject to all terms and conditions of the policy and the following limitations.

Covered Medical Expenses will be limited to Inpatient, residential, and outpatient services provided by a Hospital, nonhospital residential facility, outpatient treatment facility, or the office of a Physician, psychologist or independent clinical social worker. Before an Insured may qualify to receive benefits under this benefit, a Physician, psychologist, advanced practice registered nurse or independent clinical social worker must: 1) certify that the individual is suffering from a Mental Illness or Substance Use Disorder; 2) certify that the treatment is medically or psychologically necessary; and 3) prescribe appropriate treatment which may include referral to other treatment providers.

Benefits include the process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum.

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

### *Benefits for Child Health Screening Services*

Benefits will be paid the same as any other Sickness for uniform age-appropriate health screening requirements including childhood immunizations, consistent with the standards and schedules of the American Academy of Pediatrics, for Insured's from birth to age 21 years in the District and services outside the state for Insured's with special needs.

For the purposes of this benefit, Insured's with special needs means Insureds: 1) With physical or mental, disabilities or illnesses who reside or receive care in other states, because the District of Columbia does not have the facilities, resources, or services to appropriately treat the Insured's physical or mental, disability or illness; and 2) Whose parents or legal guardians reside in the District of Columbia.

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

### *Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects*

Benefits will be paid the same as any other Sickness for habilitative Services for the treatment of Congenital or Genetic Birth Defects. for an Insured Person, to Age 21,

For the purposes of this benefit:

Congenital or Genetic Birth Defect means: a defect existing at or from birth including a hereditary defect, autism or an autism spectrum disorder and cerebral palsy.

Habilitative Services means: services including occupational therapy, physical therapy, and speech therapy, for the treatment of a Congenital or Genetic Birth Defect to enhance the Individual Person's ability to function.

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

### *Benefits for Diabetes*

Benefits will be paid the same as any other Sickness for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Physician legally authorized to prescribe such item.

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

### *Benefits for Postpartum Care*

Benefits will be paid the same as any other Sickness for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians or the Standards for Obstetric-Gynecologic Services prepared by the American College of Obstetricians and Gynecologists, and such coverage must include an in-hospital stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Caesarean delivery.

Benefits will be provided in all cases of early discharge for post-delivery care within the minimum time periods established above to be delivered in the Insured's home, or, in a Physician's office, as determined by the Physician in consultation with the Insured. The at-home post-delivery care shall be provided by a Physician which includes a registered professional nurse, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

1) Parental education;
2) Assistance and training in breast or bottle feeding; and
3) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

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

### *Benefits for Colorectal Cancer Screening*

Benefits will be paid the same as any other Sickness for colorectal cancer screening for Insured Persons. The screening shall be in compliance with American Cancer Society colorectal cancer screening guidelines, as updated.

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

### *Benefits for Cytologic Screening and Mammographic Examinations*

Benefits will be paid the same as any other Sickness for: 1) cervical cytologic screening for women upon certification by the attending Physician that the test is a Medical Necessity; and 2) a baseline mammogram and an annual screening mammogram for women. All such services must be in accordance with the standard practice of medicine. All benefits are subject to the terms and conditions of the policy exclusive of any Deductible and Coinsurance provisions in the policy.

### *Benefits for Prostate Cancer Screening*

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening in accordance to the latest screening guidelines issued by the American Cancer Society.

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

### *Benefits for Voluntary HIV Screening Test During Emergency Room Visit*

Benefits will be paid for the cost of a voluntary HIV screening test performed on an Insured while the Insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Medical Emergency which caused the Insured to seek emergency services. Benefits shall include one emergency department HIV screening test; the cost of administering such test, all laboratory expenses to analyze the test; the cost of communicating to the Insured the results of the test and any applicable follow-up instructions for obtaining healthcare and supportive services. Benefits shall not be subject to any Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

HIV screening test shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by:

a) Conducting a rapid-result test by means of the swabbing of a patient's gums, finger-prick blood test, other suitable rapid-result test and

b) If the result is positive, conducting an additional blood test for submission to a laboratory to confirm the results of the rapid-result test.

### *Benefits for Chemotherapy Pills*

Benefits will be provided for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells. In addition, Insured Persons receiving such prescribed medication shall have the option of having it dispensed at any appropriately licensed pharmacy.

Benefits will be paid on a basis no less favorable than coverage provided intravenously administered or injected cancer medications.

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

### *Benefits for Clinical Trials*

Benefits will be paid the same as any other Sickness for Routine Patient Care Costs for those health care services, items or drugs for a Qualified Individual participating in an Approved Clinical Trial if the service, item or drug would have been a Covered Medical Expense had it not been administered in a clinical trial.

"Approved clinical trial" means:

1) A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
   a. The National Institutes of Health;
   b. The Centers for Disease Control and Prevention;
   c. The Agency for Health Care Research and Quality;
   d. The Centers for Medicare and Medicaid Services;
   e. A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
   f. The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;

"Qualified individual" means an individual who:

1) Is an Insured Person under this policy; and
2) Is eligible to participate in an Approved Clinical Trial and the Approved Clinical Trial is undertaken for the purposes of prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life threatening illness.

"Routine patient care costs" means:

1) Items, drugs, and services that are typically provided absent a clinical trial;
2) Items, drugs, and services required solely for the provision of the investigational item or service (such as administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

Routine patient care costs shall not include:

1) The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection or analysis; or
2) Items, drugs, or services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

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

## 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 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to:

UnitedHealthcare StudentResources, 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 StudentResources, PO Box 809025, Dallas, TX 75380-9025.

If you are dissatisfied with the resolution reached through the Company's Internal Appeals system regarding Medical Necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:

District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
825 North Capital Street, N.E.
6th Floor
Washington, D.C. 20002
1 (877) 685-6391
Fax: (202) 478-1397

If you are dissatisfied with the resolution reached through the Company's Internal Appeals system regarding all other grievances, you may contact the Commissioner at the following:

For Non-Medical Necessity cases:

William P. White, Commissioner
Department of Insurance, Securities and Banking
810 First St. N.E., 7th Floor Washington, D.C. 20002
(202) 727-8000
Fax: (202) 354-1085

### Right to External Independent Review

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

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

### Standard External Review

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

### Expedited External Review

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.

### Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance department at the following address:

Grievance and Appeals Coordinator
Office of the General Counselor
District of Columbia Department of Health
825-North Capitol Street, N.E., Room 4119
Washington, D.C. 20002
Phone: 202-442-5979
Fax: 202-442-4797

### Questions Regarding Appeal Rights

Contact Customer Service at 877-362-5287 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

DC Office of the Health Care Ombudsman and Bill of Rights
825 North Capitol Street, N.E., 6th Floor
Washington, DC 20002
877-685-6391
Fax: 202-478-1397
healthcareombudsman@dc.gov

## EXCLUSIONS AND LIMITATIONS

### Exclusions

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

1. Allergy, including allergy testing; except as specifically provided in the policy; (See page 11)
2. Acupuncture;
3. Learning disabilities testing, except for when referred by the designated Georgetown Learning Disability Coordinator; except as specifically provided in the policy;
4. Biofeedback or services and supplies related to biofeedback;
5. Circumcision, except for Newborn 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;
7. Dental treatment, except for Injury to Sound, Natural teeth;
8. Elective Surgery or Elective Treatment or Elective Abortion, except as specifically provided for in the Policy;
9. Vision services and supplies related to eye refractions or eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses, and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or services; except when due to disease process or Injury;
10. Services or supplies for care of corns, bunions (except capsular or bone surgery), or calluses, except for Special Benefits provided at the SHC; (See page 11)
11. Hearing examinations, except as specifically provided in the policy; or hearing aids; or other treatment for hearing defects and problems except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

12. Hirsutism, alopecia; except for Special Benefits provided at the SHC; (See page 11);
13. 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;
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 intercollegiate, club or professional sport, contest or competition; (b) traveling to or from such intercollegiate or professional sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such intercollegiate or professional sport, contest or competition;
16. Lipectomy services and supplies related to surgical or suction-assisted lipectomy;
17. Organ transplants;
18. Outpatient Physiotherapy, except as specifically provided for in the Policy Schedule of Benefits; (See page 13, Physiotherapy and Physiotherapy Other);
19. Patient controlled analgesia (PCA);
20. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; (except as specifically provided under the Benefits for Diabetes;
    b) Birth control and/or contraceptives, oral or other, whether medication or device; except as specifically provided in the policy;
    c) Immunization agents, except as specifically provided in the policy; biological sera, blood or blood products administered on an outpatient basis;
    d) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs; except as specifically provided in the policy;
    e) Products used for unapproved cosmetic purposes;
    f) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    g) Anorectics - drugs used for the purpose of weight control;
    h) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    i) Growth hormones; or
    j) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
21. Participation in a riot or civil disorder, commission of or attempt to commit a felony;
22. Reproductive/Infertility services including but not limited to: birth control; family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception (examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance reproductive ability); premarital examination; impotence, organic or otherwise; female sterilization procedures; and vasectomy; sexual reassignment surgery;
23. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
24. 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;
25. Services provided normally without charge by the SHC or services covered or provided by a student health fee;
26. Nasal and sinus surgery; except surgery made necessary as the result of a covered Injury;
27. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, or bungee jumping;
28. Sleep disorders, supplies, treatment, or testing relating to sleep disorders except when a referral obtained from the SHC accompanies a sleep disorder claim;

29. Supplies, except as specifically provided in the policy;
28. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices;
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 active duty of the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
32. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies; treatment for obesity, surgery for removal of excess skin or fat, except as specifically provided for in the Policy (See page 11 for special SHC referrals).

## Limitations

- **Club Sports** - Benefits for loss or expense caused by or resulting from Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with club sports, in excess of $25,000 per plan year will not be paid by UnitedHealthcare Insurance Company. See page 22 for a Summary of AIG Catastrophic Club Sport Coverage.

## 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 1-800-767-0700.935-5437.

- **Multiple Surgeries** - When multiple or bilateral surgical procedures are performed at the same operative session whether through one or more incisions, the Plan will pay for the major or first procedure and in addition, the plan will pay half of the payments otherwise payable for the lesser or subsequent procedures.

  When an incidental procedure (including but not limited to, incidental appendectomy, Lyses of adhesions, incision of previous scars, and puncture of ovarian cyst) is performed through the same incision, the Plan will pay for the major procedure only; and when an operative procedure is performed in two or more stages, the total payment for the combination of steps or stages which make up the entire procedure will be limited to the amount which the Plan would pay for such operative procedure if it were not performed in multiple steps or stages.

## CONTINUATION PROVISION

All Insured Persons who have been continuously insured under the school's regular student policy for at least 6 consecutive months and who no longer meet the Eligibility requirements under the Policy are eligible to continue their coverage for a period of not more than six months under the school's policy in effect. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

Information regarding the upcoming fall continuation eligibility and enrollment procedures is sent to insured students each spring. The Plan benefits in effect for the continued enrollment of otherwise ineligible Covered Persons are the same Plan benefits in effect for other Covered Persons insured within the concurrent fall term and with the same applicable fall effective date. This means that if the Plan benefits change in subsequent years, Covered Persons enrolled under the Continuation Provision will receive the subsequent Plan benefit changes.

Premium payments must be made by money order or cashier's check postmarked by August 28, 2012 and sent to:

**Georgetown University**
**Student Health Insurance Office**
**Box 571101, Henle Village #31**
**Washington, D.C. 20057-1101**

Premium Rates for Coverage Under the Six Month Continuation Plan Provisions:

| | |
|---|---|
| Student Only | $ 1,399 |
| Student and Spouse | $ 3,877 |
| Student and Child(ren) | $ 3,877 |
| Student, Spouse and Children | $ 6,085 |

* Includes a $77 Georgetown University Administrative Fee.

## SUBROGATION/RECOVERY OF BENEFITS

We may recover any benefits paid under the Policy to the extent a Covered Person is paid for the same Injury or Sickness by a third party, another insurer, or the Covered Person's uninsured motorists insurance. We may only be reimbursed to the amount of the Covered Person's recovery. Further, We have the right to offset future benefits payable to the Covered Person under the Policy against such recovery.

We may file a lien in a Covered Person's action against the third party and have a lien on any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. We shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. We will not be responsible for the Covered Person's attorney's fees or other costs.

Upon request the Covered Person must complete the required forms and return them to Us or Our authorized agent. The Covered Person must cooperate fully with Us or Our representative in asserting its right to recover. The Covered Person will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for Us to institute legal action against the Covered Person for failure to repay Us, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

## EXTENSION OF BENEFITS AFTER TERMINATION

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

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payment be made.

## COORDINATION OF BENEFITS

If a Covered Person is eligible for benefits under this policy and any other plan, We will pay benefits as explained in this provision.

**Plan** means a group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care benefits or services. These group coverages include: a) group or blanket insurance coverage, or any other group type contract or provision; b) service plan contracts, group practice and other pre-payment group coverage; c) any coverage under labor-management trustee plans, union welfare plans; employer and employee plans; and coverage under any government program, including Medicare, and any coverage required or provided by law. A primary plan pays benefits first. A secondary plan pays a reduced amount of benefits that when added to the benefits paid by the primary plan will not be more than the Allowable Expense.

**Allowable Expenses** means any necessary, reasonable and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person.

During the Policy year or benefit period, the sum of the benefits that are payable by Us and those benefits that are payable from another Plan may not be more than the Allowable Expenses. During any Policy year or benefit period, We may reduce the amount We pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made

## CONFORMITY TO STATE STATUTES

On the effective date of this Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.

## CLAIMS ADMINISTRATION AND PROCEDURES

1. A claim form is not required to submit a claim. However, an itemized medical bill, HCFA 1500, or UB92 form should be used to submit expenses. The Covered Person's name and identification number need to be included.
2. The claim form(s) should be mailed within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to the UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025. However, proof must be given as soon as reasonably possible and in no event later than one year.
3. If a prescription needs to be filled prior to receiving an ID card you will need to pay for the prescription and then seek reimbursement. Reimbursement is made upon submitting a completed Rx claim form. Claim forms can be obtained from the website, www.uhcsr.com. Within the first 90 days of the policy year, students seeking reimbursement without having their ID card, will be reimbursed for the full amount paid for the prescription less the copayment. After the first 90 days, students not using their ID card will be reimbursed at the retail price less both the copayment amount and the UnitedHealthcare Network Pharmacy discounted amount that would have been applied had the ID card been used.
4. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to UnitedHealthcare **Student**Resources.
5. Grievance Resolution: Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 1-877-935-5437. (See page 29)

### Explanation of Benefits

When a claim is processed the Covered Person will be sent an Explanation of Benefits (EOB). The EOB shows the amount of the claim submitted, the amount of the claim that was considered a Covered Expense, the portion of the Covered Expense for which the Plan paid, and the balance of the bill for which the Covered Person may be responsible. Covered Person's may also view their claims history online at www.gallagherkoster.com by selecting the "Claims Company" button on the bottom left side of the Gallagher Koster web page for Georgetown University Insureds.

## PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public 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 non-public personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-877-935-5437 or by visiting us at www.uhcsr.com.

## GALLAGHER KOSTER COMPLEMENTS

Exclusively from Gallagher Koster, enrolled students have access to the following menu of products at no additional cost. More information is available at www.gallagherkoster.com.

### *Basix Dental Savings*

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides a wide range of dental services. It is important to understand the Dental Savings Program is not dental insurance. Basix contracts with dentists that agree to charge a negotiated fee to students covered under your Gallagher Koster plan. You must pay for the services received at the time of service to receive the negotiated rate.

Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:

- Make an appointment with a contracted dentist, their fee schedules are listed on our website, www.basixstudent.com.
- Tell the dental office that you are an insured student and have access to the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility. If the office needs to check eligibility, call Gallagher Koster at 800-457-5599.
- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

Full details of the program can be viewed at the website: www.basixstudent.com. Once at the home page, select the link for your school. You may also contact us via email from our website, or by telephone at (888) 274-9961. This program is not an insurance plan offered or underwritten by UnitedHealthcare Insurance Company.

### *CampusFit*

College health is all about helping students develop healthy habits for a lifetime. To support your efforts, CampusFit "digitizes" knowledge from registered dietitians and certified fitness instructors to help teach and reinforce mainstream ideas about diet, nutrition, fitness and general wellness.

- The Energy Management section of the site allows a student to easily assess how much energy they are consuming, and expending on a daily basis. It also displays the results in the context of the Food Pyramid so students can see how to improve their food choices.
- The Fitness Works section has dozens of downloadable mp3 files and written exercise routines to help students get more active. Want to run your first 5K? We've got a nine week, step-by-step plan to get you there.
- The Wellness Support section has downloadable mp3 files for guided imagery relaxation, and dozens of recordings to reinforce fundamental diet and nutrition ideas – we've even got a 20 minute discussion on the "Freshman 15".

CampusFit is available at no cost to students. To access CampusFit, go to www.gallagherkoster.com. This program is not an insurance plan offered or underwritten by UnitedHealthcare Insurance Company.


1789