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2015–2016 Student Injury and Sickness Insurance Plan

Designed Especially for the Undergraduate Students of

VANDERBILT UNIVERSITY



VANDERBILT



Dear Students and Parents:

Vanderbilt University is committed to promoting good health and meeting the medical needs of its students. The unexpected occurrence and expense of a medical condition may interrupt and even end a student's academic career. It is for this reason that we offer the Student Injury and Sickness Insurance Plan described in this Brochure.

The University requires that all students "in degree programs" of 4 or more credits have adequate health insurance. For this reason the University will include the student insurance charge on your tuition invoice. If you have other insurance and do not wish to participate in the Student Injury and Sickness Insurance Plan offered through the University, you must complete an Online Waiver Form (www.gallagherstudent.com/vanderbilt) indicating your other insurance information. This Online Waiver Form must be completed no later than August 1, 2015, or you will remain enrolled in the Plan offered by the University and will be responsible for paying the insurance premium. All Students who wish to waive coverage are required to complete an online waiver form at the beginning of each academic year.

Although many families have some form of insurance, it's important to ensure that students have adequate coverage while on campus. The Student Injury and Sickness Insurance Plan provides coverage to students for a 12-month period, August 12, 2015 through August 11, 2016. It is your decision to waive the Student Injury and Sickness Insurance Plan, but here are some questions to think about and to ask your current health plan:

- Does my plan cover full-time students attending college away from home or even out-of-state?
- Does my plan provide adequate coverage beyond emergency services for full-time students attending college away from home or even out of state?
- Does my plan provide adequate access to health care providers outside of the plan's service area including out of state?
- Does my current plan have a high deductible that needs to be met before full coverage begins?
- How does my insurance plan cover referrals to other providers, particularly if it's an out of state referral?
- Will there be extra paperwork - how are claims submitted? Although the Plan covers many of your injuries and sicknesses, there are specific exclusions and limitations in coverage, which should be carefully noted as you read the provisions of the Plan.

We hope you enjoy your stay at Vanderbilt University.

K. Louise Hanson, MD
Medical Director
StudentHealthCenter

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-866-948-8472 or visiting us at www.uhcsr.com.

Introduction

THE VANDERBILT UNIVERSITY STUDENT INJURY AND SICKNESS INSURANCE PLAN

The Vanderbilt University Student Injury and Sickness Insurance Plan is designed to protect against unexpected medical expense and to meet most students' needs while on campus and throughout the policy year. Often a student covered by a Health Maintenance Organization (HMO) or a managed care policy at home, has limited or no benefits while at the University, other parts of the U.S. or in a foreign country. When reviewing your current policy, check to ensure that it provides access to care in the Vanderbilt University area and provides comprehensive coverage, extending beyond emergency care to include physician and hospital services.

This brochure is a brief description of the Plan. The exact provisions governing the insurance are contained in the Master Policy which becomes effective at 12:01 a.m. August 12, 2015 and terminates at 11:59 p.m. on August 11, 2016, issued to Vanderbilt University and may be viewed at the Student Health Center during regular business hours. This Plan is underwritten by UnitedHealthcare Insurance Company and is serviced by Gallagher Student Health. Claims are processed by HealthSmart Benefit Solutions, Inc.

Student Eligibility and Enrollment

All undergraduate students, with the exception of Division of Unclassified Studies (DUS) students, who are registered in degree programs for 4 or more credits (credit hours), are automatically enrolled in and billed for the Student Injury and Sickness Insurance Plan described in this brochure. Undergraduate International students should refer to the separate International Student Injury and Sickness Insurance Plan brochure describing the Eligibility and enrollment requirements for International students.

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

Online Student Waiver Process

Eligible students are automatically enrolled in and billed for the Student Injury and Sickness Insurance Plan. Students who are currently enrolled in a health insurance plan of comparable coverage that will be in effect through August 11, 2016 can waive the Student Injury and Sickness Insurance Plan. Recognizing that your current health insurance coverage may change, at the beginning of each academic year students will be asked to provide proof of comparable coverage in order to waive the Student Injury and Sickness Insurance Plan.

What is Comparable Coverage?

In order to be considered comparable, your current insurance plan should:

1. Be underwritten by an insurance company based in the United States (no international insurance companies);
2. Use a claims company in the United States;
3. Provide access to local doctors, specialists, Hospitals and other health care providers in the Vanderbilt University area;
4. Cover injury and sickness at a minimum of 80% with no policy year maximum;
5. Not have Deductibles greater than \$250 per insured person, per policy;
6. Cover inpatient and outpatient Hospital expenses, outpatient surgical expenses, inpatient and outpatient mental health, prescription drugs, laboratory tests and x-rays, physical therapy, maternity, home health care;
7. Provide coverage for Medical Evacuation and Repatriation of Remains; and
8. Provide coverage for the period of August 12, 2015 to August 11, 2016.

Waiver Deadline

The deadline for students to complete the Online Waiver Form is August 1, 2015 for annual coverage, January 6, 2016 for students newly enrolled for the Spring Semester, May 1, 2016 for students newly enrolled for May Mester, and June 1, 2016 for students newly enrolled for Summer Semester. Students who waive the Student Injury and Sickness Insurance Plan in the fall waive coverage for the entire policy year. The Online Waiver process is the only accepted process for making your insurance selection. Students who do not submit the Online Waiver Form by the deadline will remain enrolled in and billed for the Student Injury and Sickness Insurance Plan.

Waiver Process

To document proof of comparable coverage an online waiver form must be completed and submitted by the deadline.

1. Go to www.gallagherstudent.com/Vanderbilt.
2. Click on "Student Waive".
3. User Accounts have been created for all students, new and returning. Your username is your Vanderbilt University email and your Commodore ID located on your Student Account, is your password.
4. Click on the Red "I Want to Waive" button.

To complete the online Waiver Form, you will need to provide information from your current health insurance card: name, claims address, and toll-free customer service number of the insurance carrier, the name of the policyholder and policyholder ID or group number. If you have any trouble logging into your user account, please contact Gallagher Student Health & Special Risk customer service at 1-800-468-5867.

After completing the online waiver form you will be asked to review the information provided; if correct, click "Continue". Immediately upon submitting the form you will receive a confirmation number indicating the form has been submitted. Print this confirmation number for your records as it is your documentation that the form was submitted. If you do not receive a confirmation number, the form was not successfully submitted and you will need to correct any errors and resubmit the form. The online process is the only accepted process for waiving coverage.

Your submitted waiver form will be subject to a waiver verification. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Injury and Sickness Insurance Plan. An Online Waiver Form must be completed at the beginning of each academic year in order to waive participation in the Student Injury and Sickness Insurance Plan.

Students who waive the insurance and subsequently lose coverage or become ineligible for coverage under their current insurance plan (i.e. a qualifying event), have the option to complete a Petition to Add Form within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, coverage will begin the date of the qualifying event and will be in adherence to the Student Injury and Sickness Insurance Plan provisions. If a petition is received after 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Student Health & Special Risk. If the petition is approved, the premium will not be prorated. Petition to Add Forms can be obtained from Student Accounts, or online at www.gallagherstudent.com/vanderbilt.

Dependent Eligibility and Enrollment

Students may enroll their eligible Dependents with an additional cost. There are two ways to submit Dependent enrollment information. You may complete and submit the Dependent Enrollment Form available from the On-Campus Student Insurance Representative located at the Student Health Center, or you may submit an online Dependent Enrollment Form. To submit Dependent information online, go to www.gallagherstudent.com/Vanderbilt click on the "Dependent Enrollment" link.

Payment for Dependent coverage is in addition to the fee for your individual student coverage. Coverage is not effective until the start date shown in the Plan Costs and Period of Coverage section. The premium will not be prorated. It is the Insured Student's responsibility to enroll eligible Dependents each year.

Dependent Enrollment Deadlines

It is the Insured student's responsibility to enroll eligible Dependents each year. Dependents are not automatically re-enrolled. Students need to purchase coverage for their eligible dependent(s) at the same time of their initial plan enrollment and must purchase the same period of coverage in which they are enrolled.

The deadlines to enroll dependents are as follows: September 12, 2015 for newly enrolled and returning Annual students to have an effective date of August 12, 2015; February 1, 2016 for newly enrolled spring students to have an effective date of January 1, 2016; June 1, 2015 for newly enrolled May semester students to have an effective date of May 1, 2016; and July 1 2016, for newly enrolled Summer students to have an effective date of June 1, 2015.

The only time students can purchase coverage for their dependents outside of their own coverage period is if the student experiences one of the following qualifying events: (a) marriage (b) birth of a child, (c) divorce or (d) if the dependent is entering the country for the first time. If dependent enrollment meets one of these qualifying events, the Dependent Enrollment form, supporting documentation, and payment must be received by Gallagher Student Health within 31 days of the qualifying event. If not received within 31 days of the qualifying event, the effective date of coverage will be the date this form and payment are received at Gallagher Student Health. Once a dependent is enrolled, coverage cannot be terminated unless the student loses eligibility.

Dependent means the spouse (husband or wife) or Domestic Partner of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years. The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both: 1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and 2) Chiefly dependent upon the Insured Person for support and maintenance. Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age. If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

Domestic Partner means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare; and 4) is the same sex as the Named Insured. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account. "Declaration of Domestic Partnership" forms are available from either the On-Campus Student Insurance Representative located at the Student Health Center or Gallagher Student Health.

Effective and Termination Dates

The insurance under Vanderbilt University's Student Injury and Sickness Insurance Plan for the Policy Year is effective at 12:01 a.m. August 12, 2015. An eligible student's coverage becomes effective on the first day of the period for which premium is paid or date the application and full premium are received by the University or Gallagher Student Health, whichever is later. The Policy Year terminates at 11:59 p.m. August 11, 2016 or at the end of the period through which the premiums are paid, whichever is earlier.

The insurance for Spring Semester is effective on January 1, 2016 or the date the application and full premium are received by the University or Gallagher Student Health, whichever is later and terminates on August 11, 2016, or at the end of the period through which the premiums are paid, whichever is earlier.

The insurance for May Mester is effective on May 1, 2016 or the date the application and full premium are received by the University or Gallagher Student Health, whichever is later and terminates on August 11, 2016, or at the end of the period through which the premiums are paid, whichever is earlier.

The insurance for Summer Term is effective on June 1, 2016 or the date the application and full premium are received by the University or Gallagher Student Health, whichever is later and terminates on August 11, 2016, or at the end of the period through which the premiums are paid, whichever is earlier.

Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student.

The Policy is a Non-Renewable One Year Term.

Plan Costs and Period of Coverage

Rates	Annual 8/12/15 – 8/11/16	Spring 1/1/16 – 8/11/16	May Mester 5/1/16 – 8/11/16	Summer 6/1/16 – 8/11/16
Student	\$2,069	\$1,272	\$578	\$404
Spouse	\$2,054	\$1,257	\$578	\$404
One Child	\$2,054	\$1,257	\$578	\$404
Two or more Children	\$4,108	\$2,514	\$1,156	\$808
Spouse + Two or More Children	\$6,162	\$3,781	\$1,734	\$1,212

Note: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which are paid to Gallagher Student Health including Eyemed and Basix dental plan fees at the direction of your school.

Premium Refund Policy

Except for a withdrawal due to an Injury or Sickness, any Insured Student withdrawing from the University during the first 31 days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of the premium will be made. Insured Students withdrawing after 31 days will remain covered under the Plan for the full period for which the premium has been paid and no refund will be made available. This is true for students on an approved leave for medical or academic reasons, graduating students and students electing to enroll in a separate comparable plan during the policy year. Premium received by the Company is fully earned upon receipt.

Coverage for an Insured Student entering the Armed Forces of any country will terminate as of the date of such entry. Those Insured Students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request.

Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured incurs Covered Medical Expenses within 31 days of the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as follows provided the condition continues:

1. When not Hospital Confined on the Termination Date, not to exceed 31 days after the Termination Date; or
2. When Hospital Confined on the Termination Date, not to exceed 90 days after the Termination Date.

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

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

If the Insured is also an insured under the succeeding policy issued to the Policyholder; this "Extension of Benefits" provision will not apply.

Pre-Admission Notification

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

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

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

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

Preferred Provider Information

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

VU Medical Center and UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-844-210-0545 and/or by asking the provider when making an appointment for services.

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

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

"Network Area" means the 40 mile radius around the local school campus the Named Insured is attending.

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include VU Medical Center and UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities. Call 1-844-210-0545 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

Schedule of Medical Expense Benefits

Metallic level: Platinum

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible Preferred Provider	\$250 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network	\$500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Providers	90% except as noted below
Coinsurance Out-of-Network	80% except as noted below
Out-of-Pocket Maximum Preferred Providers	\$5,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Providers	\$10,000 (For all Insureds in a Family, Per Policy Year)

The Preferred Providers are VU Medical Center and UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider with the necessary expertise is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced, or lower benefits will be provided when an Out-of-Network provider is used.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network per service Deductibles.

Important: The Deductible will be waived and benefits will be paid for 100% of Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. A referral from the Student Health Center to an outside provider is required (see Referral Process provision for referral requirements).

NOTE: The exclusion will be waived and benefits will be paid for the treatment of Hirsutism and Alopecia when determined to be a Medical Necessity.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Please refer to the Medical Expense Benefits – Injury and Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider	Out-of-Network
Room and Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges

Inpatient	Preferred Provider	Out-of-Network
Pre-admission Testing Payable within 7 working days prior to admission.	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.	Preferred Allowance	80% of Usual and Customary Charges
Diagnostic X-Ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Prescription Drugs An additional \$100 per policy year Deductible will be required. Prescriptions not filled at an Express-Script Pharmacy or Mail Service Program will not be covered.	\$10 Copay per prescription for generic drugs \$25 Copay per prescription for brand name drugs \$45 Brand with Generic Equivalent based on a 30-day supply per prescription <i>Prescriptions must be filled at a Express Scripts network pharmacy. Prescriptions can be filled by mail order through Express Scripts pharmacies only. Insureds may get a 90-day supply of prescription medication by paying a Copay 2 times the monthly tier Copay. Mail order prescriptions will not be filled less than 45 days from the termination date of the policy.</i>	No Benefits

Other	Preferred Provider	Out-of-Network
Ambulance Services	100% of Actual Charges	100% of Actual Charges
Durable Medical Equipment	80% of Usual and Customary Charges	80% of Usual and Customary Charges
Consultant Physician Fees	Preferred Allowance	Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	100% of Actual Charges	100% of Actual Charges
Mental Illness Treatment Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	Paid as any other Sickness
Maternity	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.	100% of Preferred Allowance	80% of Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes Treatment	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	80% of Preferred Allowance	80% of Usual and Customary Charges
Hospice Care	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	Preferred Allowance	Usual and Customary Charges
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids Benefits are limited to Insureds under 18 years of age.	Preferred Allowance	Usual and Customary Charges
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges
Learning Disability Testing Initial diagnostic testing only	Paid as any other Sickness	Paid as any other Sickness

Prescription Drug Expense Benefit

These services are not provided or underwritten by UnitedHealthcare Insurance Company.

Mail Service Prescription Drug Program

Medications that are taken for a chronic condition can be filled for up to a 90-day supply using Express-Scripts' Mail Service Prescription Program. Using the Mail Service program, a 90-day supply of a generic can be filled with a \$20 copayment, a 90-day supply of a brand name drug can be filled for \$50 and a 90-day supply of a brand name with generic equivalent drug can be filled for \$90. Mail order prescriptions will not be filled less than 45 days from the termination date of the policy. When you use the Mail Service Prescription Drug Program you will need to complete an "Express-Scripts By Mail" Order Form and include that and your doctor's signed prescription form and mail directly to Express-Scripts. A brochure describing the Mail Service Program, "Express-Scripts By Mail", Order Forms and accompanying mailing envelope are available at the Student Health Center or by contacting Gallagher Student Health.

Not all medications are covered under the prescription benefit (retail or mail service). Expenses incurred for the following are excluded under the Plan: fertility medications; legend vitamins or food supplements; smoking deterrents; immunization agents and vaccines, except as provided in the policy; biological sera; blood plasma; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed at a Hospital or rest home. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: (a) the American Medical Association Drug Evaluations; (b) the American Hospital Formulary Service Drug Information; (c) the United States Pharmacopoeia Drug Information; or (d) it is recommended by a clinical study or review article in a major peer-reviewed professional journal. However, Covered Medical Expenses do not include experimental or investigational drugs, or any drug, which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

To locate a participating pharmacy, call 1-800-711-0917 or visit www.express-scripts.com

Medical Expense Benefits – Injury and Sickness

This section describes Covered Medical Expenses for which benefits are available in the Schedule of Benefits.

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance, Copayment or per service Deductible amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

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

Inpatient

1. **Room and Board Expense.**
Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.
2. **Intensive Care.**
If provided in the Schedule of Benefits.
3. **Hospital Miscellaneous Expenses.**
When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
Benefits will be paid for services and supplies such as:
 - The cost of the operating room.
 - Laboratory tests.
 - X-ray examinations.
 - Anesthesia.

- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. **Routine Newborn Care.**

While Hospital Confined and routine nursery care provided immediately after birth.

Benefits will be paid for an inpatient stay of at least:

- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.

5. **Surgery (Inpatient).**

Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**

Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**

Registered Nurse's services which are all of the following:

- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.

9. **Physician's Visits (Inpatient).**

Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

10. **Pre-admission Testing.**

Benefits are limited to routine tests such as:

- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the policy, major diagnostic procedures such as those listed below will be paid under the "Hospital Miscellaneous" benefit:

- CT scans.
- NMR's.
- Blood chemistries.

Outpatient

11. **Surgery (Outpatient).**

Physician's fees for outpatient surgery.

12. **Day Surgery Miscellaneous (Outpatient).**

Facility charge and the charge for services and supplies in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.

13. **Assistant Surgeon Fees (Outpatient).**
Assistant Surgeon Fees in connection with outpatient surgery.
14. **Anesthetist Services (Outpatient).**
Professional services administered in connection with outpatient surgery.
15. **Physician's Visits (Outpatient).**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery.
- Physician's Visits for preventive care are provided as specified under Preventive Care Services.
16. **Physiotherapy (Outpatient).**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
 - Occupational therapy.
 - Cardiac rehabilitation therapy.
 - Manipulative treatment.
 - Speech therapy.
17. **Medical Emergency Expenses (Outpatient).**
Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies.
- All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. **Diagnostic X-ray Services (Outpatient).**
Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
19. **Radiation Therapy (Outpatient).**
See Schedule of Benefits.
20. **Laboratory Procedures (Outpatient).**
Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
21. **Tests and Procedures (Outpatient).**
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
- Physician's Visits.
 - Physiotherapy.
 - X-rays.
 - Laboratory Procedures.
- The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
 - Infusion therapy.
 - Pulmonary therapy.
 - Respiratory therapy.
- Tests and Procedures for preventive care are provided as specified under Preventive Care Services.
22. **Injections (Outpatient).**
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy (Outpatient).**

See Schedule of Benefits.

24. **Prescription Drugs (Outpatient).**

See Schedule of Benefits.

Other

25. **Ambulance Services.**

See Schedule of Benefits.

26. **Durable Medical Equipment.**

Durable Medical Equipment must be all of the following:

- Provided or prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Primarily and customarily used to serve a medical purpose.
- Can withstand repeated use.
- Generally is not useful to a person in the absence of Injury or Sickness.
- Not consumable or disposable except as needed for the effective use of covered durable medical equipment.

For the purposes of this benefit, the following are considered durable medical equipment.

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part.

If more than one piece of equipment or device can meet the Insured's functional need, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

27. **Consultant Physician Fees.**

Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**

Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Sound, Natural Teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. Pediatric dental benefits are provided in the Pediatric Dental Services provision.

Benefits will also be provided for the Hospital or facility charges, nursing, and general anesthesia services performed in connection with an Inpatient or outpatient dental procedure for the following:

- Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery.
- Concomitant systemic disease which the Insured is under current medical management and that significantly increases the probability of complications.
- Mental Illness or behavioral condition of the Insured Person that precludes dental surgery in the office.
- Use of general anesthesia and the Insured's medical condition requires that such procedure be performed in a Hospital.
- And for Insured's 8 years or younger where such procedure cannot be safely provided in a dental office setting.

This does not include expenses for the dental procedure.

29. **Mental Illness Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
 - On an outpatient basis including intensive outpatient treatment.
30. **Substance Use Disorder Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
 - On an outpatient basis including intensive outpatient treatment.
31. **Maternity.**
Same as any other Sickness.
- Benefits will be paid for an inpatient stay of at least:
- 48 hours following a vaginal delivery.
 - 96 hours following a cesarean section delivery.
- If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.
32. **Complications of Pregnancy.**
Same as any other Sickness.
33. **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:
- 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*.
 - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
 - 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*.
 - With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
34. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Reconstructive Breast Surgery.
35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes Treatment.
36. **Home Health Care.**
Services received from a licensed home health agency that are:
- Ordered by a Physician.
 - Provided or supervised by a Registered Nurse in the Insured Person's home.
 - Pursuant to a home health plan.
- Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.

37. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.
Hospice care includes:
- Physical, psychological, social, and spiritual care for the terminally ill Insured.
 - Short-term grief counseling for immediate family members while the Insured is receiving hospice care.
38. **Inpatient Rehabilitation Facility.**
Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.
39. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
- In lieu of Hospital Confinement as a full-time inpatient.
 - Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.
40. **Urgent Care Center.**
Benefits are limited to:
- The facility or clinic fee billed by the Urgent Care Center.
- All other services rendered during the visit will be paid as specified in the Schedule of Benefits.
41. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- The facility or clinic fee billed by the Hospital.
- All other services rendered during the visit will be paid as specified in the Schedule of Benefits.
42. **Approved Clinical Trials.**
Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.
- "Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include:
- The experimental or investigational item, device or service, itself.
 - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
 - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- "Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials that meet required conditions.
 - The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
 - The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

43. **Transplantation Services.**

Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under this policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this policy to be primary.

No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.

Travel expenses are not covered. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

44. **Hearing Aids.**

Hearing aids for Insureds under 18 years of age when required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. If more than one type of hearing aid can meet the Insured's functional needs, benefits are available only for the hearing aid that meets the minimum specifications for the Insured's needs. Benefits are limited to one hearing aid per hearing impaired ear every 36 months.

45. **Medical Supplies.**

Medical supplies must meet all of the following criteria:

- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

Benefits are limited to a 31-day supply per purchase.

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
- Cystic fibrosis screening

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), non-invasive fetal aneuploidy DNA testing

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, except folic acid supplements with a written prescription. For additional information regarding Maternity Testing, please call the Company at 1-844-210-0545.

Mandated Benefits

Benefits for Mammography

Benefits will be paid the same as any other Sickness for mammography screening performed on dedicated equipment for diagnostic purposes on referral by an Insured's Physician, according to the following guidelines:

1. A baseline mammogram for women ages thirty-five to forty.
2. A mammogram every two years, or more frequently based on the recommendation of the woman's Physician, for women ages forty to fifty.
3. A mammogram every year for women fifty years of age and over.

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

Benefits for Phenylketonuria Treatment

Benefits will be paid the same as any other Sickness for treatment of phenylketonuria. Benefits shall include licensed professional medical services under the supervision of a Physician and for Usual and Customary Charges for special dietary formulas which are Medically Necessary for the therapeutic treatment of phenylketonuria.

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

Benefits for Diabetes Treatment

Benefits will be paid the same as any other sickness for the following Medically Necessary equipment, supplies, and services for the treatment of diabetes, when prescribed by a Physician:

- Blood glucose monitors and blood glucose monitors for the legally blind;
- Test strips for the glucose monitors;
- Visual readings and urine test strips;
- Insulin; injection aids; syringes; lancets; insulin pumps; insulin infusion devices; and appurtenances thereto;
- Oral hypoglycemic agents;
- Podiatry appliances for prevention of complications associated with diabetes;
- Glucagon emergency kits;
- Education of Insured Persons with diabetes as to the proper self-management and treatment of their diabetes, including: Diabetes outpatient self-management training and educational services, including medical nutrition counseling. Diabetes outpatient self-management training and education shall be limited to the following: (1) Visits which are certified by a Physician to be Medically Necessary upon the diagnosis of diabetes in an Insured; (2) Visits which are certified by a Physician to be Medically Necessary because of a significant change in an Insured's symptoms

or condition which necessitates changes in the Insured's self-management; and (3) Visits which are certified by a Physician to be Medically Necessary for re-education or refresher training.

Diabetes outpatient self-management training and educational services may be provided in group settings where practicable, and shall include home visits where Medically Necessary.

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

Benefits for Prostate-Specific Antigen (PSA) Tests

Benefits will be paid the same as any other Sickness for Prostate-Specific Antigen (PSA) Tests upon the recommendation of a Physician for the early detection of prostate cancer for an Insured Person aged fifty (50) and over and other Insured Persons if a Physician determines that early detection for prostate cancer is Medically Necessary.

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

Benefits for Reconstructive Breast Surgery

Benefits will be paid the same as any other Sickness, for all stages of reconstructive breast surgery including the cost of prostheses following a covered mastectomy (but not a lumpectomy) on one or both breasts to restore and achieve symmetry between the two breasts.

The surgical procedure performed on a nondiseased breast to establish symmetry with the diseased breast must occur within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.

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

Benefits for Osteoporosis

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of osteoporosis, including screening by a Qualified Individual for scientifically proven Bone Mass Measurement (bone density testing).

Bone mass measurement means a radiologic or radioisotopic procedure or other scientifically proven technologies performed on an individual for the purpose of identifying bone mass or detecting bone loss.

Qualified individual means a person with a condition for which bone mass measurement is determined to be Medically Necessary by the person's attending Physician or primary care Physician.

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

Benefits for Hearing Screening Tests for Newborn Infants

Benefits will be paid the same as any other Sickness for Newborn Infants for Hearing Screening Tests. "Hearing Screening Test" means a screening or test provided in accordance with current hearing screening standards established by a nationally recognized organization such as the Joint Committee on Infant Hearing Screening of the American Academy of Pediatrics.

A child born in a Hospital or other birthing facility shall be screened for hearing loss prior to discharge from that facility. The Physician shall refer a child born in a setting other than a Hospital or other birthing facility to the Department of Health or an appropriate hearing screening provider as listed in the latest edition of the Directory of Hearing Screening Providers in Tennessee for hearing screening. A child born on an emergency basis in a Hospital that does not otherwise provide obstetrical or maternity services and which does not provide infant Hearing Screening Tests prior to discharge shall refer a child born in that facility to the Department of Health or an appropriate hearing screening provider as listed in the latest edition of the Directory of Hearing Screening Providers in Tennessee for hearing screening. All screening providers or entities shall report their screening results to the department of health.

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

Benefits for Autism Spectrum Disorders

Benefits will be paid the same as any other Sickness for Autism Spectrum Disorders.

“Autism Spectrum Disorders” means neurological disorders, usually appearing in the first three years of a child’s life that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive, and stereotyped behaviors.

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

Coordination of Benefits Provision

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

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of

Life	\$10,000
Both Hands, Both Feet, or Sight of Both Eyes	\$10,000
One Hand and One Foot	\$10,000
Either One Hand or One Foot and Sight of One Eye	\$10,000
One Hand or One Foot or Sight of One Eye	\$ 5,000

Loss shall mean with regard to hands and feet, 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.

Student Health Center

The Student Health Center provides primary care services for students and is staffed by physicians, nurse practitioners, nurses and a lab technician. The Student Health Center provides services similar to those provided in a private physician’s office or HMO, including routine medical care, specialty care (e.g. nutrition and sports medicine), and some routine lab tests, including one pre-paid annual (per policy year) cytological screen (Pap smear and exam) for Insured students in the Student Injury and Sickness Insurance Plan. Most of the services students receive at the Student Health Center are pre-paid, but those services that are not are the responsibility of students to coordinate with their health insurance.

When the University is in session, during fall and spring semesters, the Student Health Center is open Monday through Friday from 8:00 a.m. to 4:30 p.m., and Saturdays from 8:30 a.m. to 12:00 p.m. Students should call ahead to schedule an appointment at 322-2427. Students with urgent problems will be seen on a same-day basis. They will be given an appointment that day, or “worked in” on a first-come, first-serve basis if no appointments are available. Emergency consultations services (322-2427) are available 24-hours a day, 7 days a week from on-call professionals. For more detailed information on the services available at the Student Health Center and information on other health-related topics, please visit the Student Health Center website at <https://medschool.vanderbilt.edu/student-health>.

Wellness Benefit:

The Wellness Benefit is a separate program that is not underwritten by or administered by UnitedHealthcare Insurance Company.

Students enrolled in the Student Injury and Sickness plan will receive a Wellness Benefit for certain immunizations and STI testing at the Student Health Center only. The Wellness Benefit includes the following immunizations: HPV (Gardasil, all males and females over age 26), Japanese encephalitis, pneumovax (individuals under 65), polio, rabies and Yellow Fever. The

Wellness Benefit includes the following STI tests: Chlamydia (all males and females over age 25) and gonorrhea (all males). (Note – some immunizations and STI tests are covered under the Student Injury and Sickness Insurance Plan's Preventive Care Services).

Copay per immunization: \$5

Copay per STI test: \$8

Maximum Benefit: \$300 per policy year

The student is responsible for any charges incurred which exceed the \$300 per policy year maximum, payable either out of pocket, or their tuition statement/student account will be charged.

Dependents of students enrolled in the plan are not eligible for the Wellness Benefit.

Referral Process

When the Student Health Center is open, Insured Students must first seek care and treatment at the Student Health Center. When the medical staff determines that a student requires the care of a non-health center provider, a written referral will be made for that particular Sickness or Injury. **Each Injury or Sickness is a separate condition and a separate written referral is required for each condition, each policy year, in order to receive the benefits allowed in this Plan. Only one referral is required for each Injury or sickness per Policy Year. A referral from the Student Health Center does not guarantee that the services will be covered by the Student Injury and Sickness Insurance Plan.** Treatment received without a written referral authorization will not be covered, except for the circumstances listed below. Treatment that requires a referral will be covered in accordance with the Schedule of Benefits on pages 6-8. A referral issued by the Student Health Center must accompany the claim when submitted. Covered Dependents do not use services at the Student Health Center and are not required to obtain a written referral.

Exceptions to the Referral Process:

1. When the Student Health Center is closed.
2. Medical Emergency or Emergencies. The student must return to the Student Health Center for necessary follow-up care.
3. When service is rendered at another facility during break or vacation periods.
4. Medical care received when an Insured Student is more than 40 miles from the Vanderbilt University campus.
5. Medical care received when an Insured Student is no longer eligible to use the Student Health Center due to a change in student status.
6. Insured Dependents.
7. Maternity, obstetrical and gynecological care.
8. Mental Illness Treatment and Substance Use Disorder Treatment.

Student Health Insurance Benefits

This Plan provides benefits based on the type of health care provider you or your covered Dependent select. This Plan provides access to a Preferred Provider Organization (PPO) with Preferred Providers/facilities locally and nationwide.

Definitions

ADOPTED CHILD means the adopted child placed with an Insured while that person is covered under this policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted child not more than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured's residence.

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

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

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

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at birth.

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

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

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

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

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

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

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

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

EMERGENCY SERVICES means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

HABILITATIVE SERVICES means outpatient occupational therapy, physical therapy and speech therapy prescribed by the Insured Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

Habilitative services do not include services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Insured Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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 is not an institution specializing in or primarily treating Mental Illness and Substance Use Disorders except for the following: 1) a hospital licensed under Tennessee Title 33, Chapter 2 or Title 68, Chapter 11, Part 2 and accredited by the joint commission on the accreditation of hospitals; 2) a hospital owned or operated by the state of Tennessee that is especially intended for use in the diagnosis, care and treatment of Mental Illness; or 3) for the treatment of Substance Use Disorders, a facility that is a residential treatment facility licensed under Tennessee Title 33, Chapter 2, Part 4 and accredited by the joint commission on the accreditation of hospitals.

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

INJURY means bodily injury which is all of the following:

1. unrelated to any pathological, functional, or structural disorder.
2. a source of loss.
3. treated by a Physician within 30 days after the date of accident.
4. sustained while the Insured Person is covered under this policy.

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

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

INPATIENT REHABILITATION FACILITY means a long term acute inpatient rehabilitation center, a Hospital (or special unit of a Hospital designated as an inpatient rehabilitation facility) that provides rehabilitation health services on an Inpatient basis as authorized by law.

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

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

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

MEDICAL EMERGENCY means Sickness or Injury that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in any of the following:

1. Placement of the Insured's health in jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any body organ or part.

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/MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

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

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

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

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

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

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

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for: 1) Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; 2) routine nursery care provided in the well-child care unit; and 3) perinatal group B streptococcal disease testing. Benefits will be the same as for the Insured Person who is the child's parent.

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

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

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 short-term outpatient rehabilitation therapies (including Habilitative Services) 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 mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

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

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

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

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

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

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

Exclusions and Limitations

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

1. Circumcision.
2. Cosmetic procedures, except reconstructive procedures to:
 - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
 - Treat or correct Congenital Conditions.
3. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 - As described under Dental Treatment in the policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
4. Elective Surgery or Elective Treatment.
5. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
6. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:

 - Hearing defects or hearing loss as a result of an infection or Injury.
 - Benefits specifically provided in the policy.
7. Hirsutism. Alopecia.
8. 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.
9. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
10. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
11. Injury sustained while:
 - Participating in any interscholastic, intercollegiate, or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
12. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting except when unprovoked and in self-defense.
13. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
 - Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
14. Reproductive/Infertility services including but not limited to the following:
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception except to diagnose or treat the underlying cause of the infertility.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Reversal of sterilization procedures.
 - Sexual reassignment surgery.
15. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.

This exclusion does not apply as follows:

- When due to a covered Injury or disease process.
 - To benefits specifically provided in Pediatric Vision Services.
 - To the first pair of eyeglasses or contact lenses following cataract surgery.
16. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
 17. Preventive care services, except as specifically provided in the policy, including:
 - Routine physical examinations and routine testing.
 - Preventive testing or treatment.
 - Screening exams or testing in the absence of Injury or Sickness.
 18. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
 19. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
 20. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
 21. Supplies, except as specifically provided in the policy.
 22. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
 23. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
 24. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat.

UnitedHealthcare Global: Global Emergency Services

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

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

The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccines
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to \$5,000.00 payment (when included with Your enrollment in a UnitedHealthcare **StudentResources** health insurance policy)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains

- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit www.uhcsr.com/UHCGlobal for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

1-(800) 527-0218 Toll-free within the United States

1-(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at assistance@UHCGlobal.com.

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

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

UnitedHealthcare Global 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 UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. Please refer to the UnitedHealthcare Global information in **My Account** at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

NurseLine and Student Assistance

Insureds have immediate access to nurse advice, a health information library, and counseling support 24 hours a day by calling the toll-free number listed on their medical ID card. NurseLine is staffed by both English and Spanish speaking Registered Nurses who can provide health information, support, and guidance on when to seek medical care. The Student Assistance Program coordinates services using a network of resources. Services available include financial and legal advice, as well as mediation. Counseling is also available by Licensed Clinicians who can provide insureds with someone to talk to when everyday issues become overwhelming. Translation services are available in over 170 languages for most services. Insureds also have access to LiveAndWorkWell.com where they can take health risk assessments, use health estimators to calculate things like their target heart rate and BMI, and participate in personalized self-help programs. More information about these services is available by logging into **My Account** at www.uhcsr.com/MyAccount.

Online Access to Account Information

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

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

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

Right of Recovery

Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear. This provision will be limited to 18 months from the date the claim is paid.

Subrogation

If an Insured recovers money for medical expenses incurred due to an Injury for which the Company paid a medical benefit, the Company must be repaid. The amount repaid will not exceed the smaller of the amount the Insured recovers for medical expenses incurred or the amount of benefits paid. The repayment will come out of any recovery made for medical expenses, less an equitable adjustment for the costs and legal fees needed to recover the money. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

Claim Procedures for Injury and Sickness Benefits

In the event of an Injury or Sickness the Insured Student should:

1. If at Vanderbilt University report to the Student Health Center for proper treatment or referral; or
2. If away from Vanderbilt University or if the Student Health Center is closed, report to the nearest Physician or Hospital and follow the prescribed treatment advice. The Insured Student should return to the Student Health Center for any necessary follow up care.
3. 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 Insured Student/Person's name and identification number need to be included.
4. The 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 UnitedHealthcare **StudentResources**, at the address below. However, proof must be given as soon as reasonably possible and in no event later than one year.
5. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, HealthSmart Benefit Solutions, Inc., or to the On-Campus Student Insurance Representative.

REMEMBER THAT EACH INJURY OR SICKNESS IS A SEPARATE CONDITION. ONLY ONE REFERRAL IS REQUIRED FOR EACH INJURY OR SICKNESS EACH POLICY YEAR. A REFERRAL FROM THE STUDENT HEALTH CENTER DOES NOT GUARANTEE THAT THE SERVICES WILL BE COVERED BY THE STUDENT INJURY AND SICKNESS INSURANCE PLAN.

Any provision of this Policy, which on the effective date, is in conflict with the statutes of the state in which the Policy is issued will be administered to conform to the requirements of the state statutes.

Claims Status and all other Claim Inquires:

Claims Administrator
HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
1-844-210-0545
Email: akronclaims@healthsmart.com

Pediatric Dental Services Benefits

Benefits are provided for Covered Dental Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) date Year the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

Network Benefits apply when the Insured Person chooses to obtain Covered Dental Services from a Network Dental Provider. Insured Persons generally are required to pay less to the Network Dental Provider than they would pay for services from a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will the Insured Person be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, the Insured must obtain all Covered Dental Services directly from or through a Network Dental Provider.

Insured Persons must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. Participation status can be verified by calling the Company and/or the provider. If necessary, the Company can provide assistance in referring the Insured Person to a Network Dental Provider.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 1-844-210-0545 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured's ID card.

Non-Network Benefits apply when Covered Dental Services are obtained from non-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. As a result, an Insured Person may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. In addition, when Covered Dental Services are obtained from non-Network Dental Providers, the Insured must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

Benefits are eligible for Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed \$300 or if a dental exam reveals the need for fixed bridgework, the Insured Person may receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the policy.

A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets the Insured Person know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If the Insured Person does not obtain a pre-authorization, the Company has a right to deny the claim for failure to comply with this requirement.

If a treatment plan is not submitted, the Insured Person will be responsible for payment of any dental treatment not approved by the Company. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:

- A. Necessary.
- B. Provided by or under the direction of a Dental Provider.
- C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.
- D. Not excluded as described in Section 3: Pediatric Dental Services exclusions.

Dental Services Deductible

Benefits for pediatric Dental Services provided are not subject to the policy Deductible stated in the policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Policy Year is \$500 per Insured Person.

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 1 set of films every 6 months.	50%	50%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 film every 60 months.	50%	50%
Periodic Oral Evaluation (Checkup Exam) Limited to 1 every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	50%	50%
Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 1 every 6 months.	50%	50%
Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50%	50%
Sealants (Protective Coating) Limited to one sealant per tooth every 36 months.	50%	50%
Space Maintainers		
Space Maintainers Limited to one per 60 months. Benefit includes all adjustments within 6 months of installation.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50%	50%
Periodontal Surgery (Gum Surgery) Limited to one quadrant or site per 36 months per surgical area.	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to once per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	50%	50%
Endodontics (root canal therapy) performed on anterior teeth, bicuspid, and molars Limited to once per tooth per lifetime. Endodontic Surgery	50%	50%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50%	50%
Oral Surgery, including Surgical Extraction	50%	50%
Adjunctive Services		
General Services (including Emergency Treatment of dental pain) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary.	50%	50%
Occlusal guards for Insureds age 13 and older Limited to one guard every 12 months.	50%	50%
Major Restorative Services		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Fixed Prosthetics (Bridges) Limited to once per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures) Limited to one per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per 24 months.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Implants		
Implant Placement Limited to once per 60 months.	50%	50%
Implant Supported Prosthetics Limited to once per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to once per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report Limited to once per 60 months.	50%	50%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to once per 60 months.	50%	50%
Repair Implant Abutment by Support Limited to once per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report Limited to once per 60 months.	50%	50%
MEDICALLY NECESSARY ORTHODONTICS		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.		
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	50%	50%

Section 3: Pediatric Dental Exclusions

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy. Except as may be specifically provided under Section 2: Benefits for Covered Dental Services, benefits are not provided for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

Reimbursement for Dental Services

The Insured Person is responsible for sending a request for reimbursement to the Company, on a form provided by or satisfactory to the Company.

Claim Forms

It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began.
- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage the Insured Person must include the name of the other carrier(s).

To file a claim, submit the above information to the Company at the following address:

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-844-210-0545. This number is also listed on the Insured's Dental ID Card.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

Covered Dental Service – a Dental Service or Dental Procedure for which benefits are provided under this endorsement.

Dental Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to the Insured Person while the policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary Fees, as defined below.

Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Insured Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy:
 - For treating a life threatening dental disease or condition.
 - Provided in a clinically controlled research setting.
 - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this endorsement. The definition of Necessary used in this endorsement relates only to benefits under this endorsement and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Usual and Customary Fee - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary Fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that the Company accepts.

Pediatric Vision Care Services Benefits

Benefits are provided for Vision Care Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) date the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-844-210-0545. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When Vision Care Services are obtained from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then seek reimbursement from the Company as described under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, the Insured Person will be required to pay any Copayments at the time of service.

Network Benefits

Benefits for Vision Care Services are determined based on the negotiated contract fee between the Company and the Vision Care Provider. The Company's negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Non-Network Benefits

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

Policy Deductible

Benefits for pediatric Vision Care Services are not subject to any policy Deductible stated in the policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for Vision Care Services does not apply to the policy Deductible stated in the policy Schedule of Benefits.

Benefit Description

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copayments and Coinsurance stated under each Vision Care Service in the Schedule of Benefits below.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well the Insured sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses - Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations. The following Optional Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames - A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Contact Lenses - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

The Insured Person is eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Insured Person selects more than one of these Vision Care Services, the Company will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of \$20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of \$40.	50% of the billed charge.
• Bifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Trifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Lenticular		100% after a Copayment of \$40.	50% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to \$130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - \$160.		100% after a Copayment of \$15.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$160 - \$200.		100% after a Copayment of \$30.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - \$250.		100% after a Copayment of \$50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.		60%	50% of the billed charge.
Contact Lenses	Limited to a 12 month supply.		
• Covered Contact Lens Selection		100% after a Copayment of \$40.	50% of the billed charge.
• Necessary Contact Lenses		100% after a Copayment of \$40	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy.

Except as may be specifically provided under Section 1: Benefits for Pediatric Vision Care Services, benefits are not provided for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in Section 1: Benefits for Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company.

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), the Insured Person must provide all of the following information at the address specified below:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
Fax: 1-806-473-3136

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in Section 1: Benefits for Pediatric Vision Care Services.

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 1-844-210-0545 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: HealthSmart Benefit Solutions, Inc., 3320 West Market Street, Suite 100, Fairlawn, OH 44333-3306.

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 1-844-210-0545. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, HealthSmart Benefit Solutions, Inc., 3320 West Market Street, Suite 100, Fairlawn, OH 44333-3306.

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 6 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited External Review

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

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

Standard Experimental or Investigational External Review

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

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 6 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational External Review

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

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

Where to Send External Review Requests

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

Claims Appeals
HealthSmart Benefit Solutions, Inc.,
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
1-844-210-0545

Questions Regarding Appeal Rights

Contact Customer Service at 1-844-210-0545 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

Tennessee Department of Commerce and Insurance
Consumer Insurance Services
500 James Robertson Pkwy, 4th Floor
Nashville, TN 37243-0574
(800) 342-4029
(615) 741-2218
(615) 532-7389 (fax)
www.tn.gov/commerce
CIS.Complaints@tn.gov

Gallagher Student Health & Special Risk Complements

Exclusively from Gallagher Student Health & Special Risk, the following menu of products are provided to all students currently enrolled in this Plan. These plans are not underwritten by UnitedHealthcare Insurance Company. For more information on all of the products & services listed below, visit your school's page at www.gallagherstudent.com under the "Discounts and Wellness" tab.

EyeMed Vision Care

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network offers access to over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% and 45% off regular retail pricing. In addition, you can receive discounts off laser correction surgery at some of the nation's most highly-qualified laser correction surgeons. You can take advantage of the savings immediately using your EyeMed ID card, which can be printed from the "Discounts and Wellness" tab on your school's page at www.gallagherstudent.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 at reduced costs for students enrolled in a Gallagher Student Health & Special Risk Insurance Plan. 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 the Gallagher Student Health & Special Risk plan.

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:

- Find a contracted dentist from the Basix website.
- Make an appointment with a contracted dentist- be sure to tell the dental office that you have access to the Basix Dental Savings program. 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.
- Payment must be made at the time of service in order to receive the negotiated rate.

Full details of the program including lists of contracted dentists and fee schedules can found at www.basixstudent.com.

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 assess how much energy they are consuming, and expending on a daily basis and offers ways to improve food choices.
- The Fitness Works section offers 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.

The CampusFit website can be accessed at <http://campusfit.basixwellness.com>. Registration is fast, free and completely confidential.

The Plan is Underwritten by:
UnitedHealthcare Insurance Company

QUESTIONS? NEED MORE INFORMATION?

For general information on benefits, eligibility and enrollment, ID Cards, please contact:

Gallagher Student Health & Special Risk

500 Victory Road

Quincy, MA 02171

1-617-769-6060 or 1-800-468-5867

Email: VUStudent@gallagherstudent.com

www.gallagherstudent.com/Vanderbilt

For information about Gallagher Student Health & Special Risk Complement, EyeMed, Basix Dental and Campus Fit, go to www.gallagherstudent.com/Vanderbilt and click on Discounts & Wellness.

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

This Brochure is based on Policy # 2015-99-1

v2 NOC4 (10/7/15)





POLICY NUMBER: 2015-99-1

NOTICE:

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

NOC#4 (10/7/15)

1. Preferred Provider Information page: changed customer service phone number from 1-866-948-8472 to 1-844-210-0545

NOC#3 (9/30/15)

1. Referral Process section: added to list of referral exceptions – 3. When service is rendered at another facility during break or vacation periods.

NOC#2 (7/23/15)

Notice of Appeal Rights

The time limit for both Standard External Review and Standard Experimental or Investigational External Review has been revised from 4 months to 6 months as below:

Standard External Review

A Standard External Review request must be submitted in writing within 6 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Standard Experimental or Investigational External Review

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

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 6 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

NOC#1 (7/20/15)

1. Updated Healthsmart phone number from 1-877-349-9017 to 1-844-210-0545