

2009 - 2010
UnitedHealthcare Insurance Company

Student Injury
and
Sickness Insurance Plan
Description of Benefits

Premier Plan



GEORGETOWN UNIVERSITY

Designed especially for the students of

Georgetown University



OBTAINING ADMINISTRATIVE ASSISTANCE

ID cards, questions about health benefits, vision, or dental Plans, and customer service issues

Gallagher Koster
500 Victory Road
Quincy, MA 02171
877-362-5287
617-479-0860 (fax)
www.gallagherkoster.com
StudentInsurance@gallagherkoster.com

Claim Submission and Questions for Medical and Prescription Claims

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025
1-877-935-5437
Claims@uhcsr.com

Online access to claims status, Explanation, of Benefits, correspondence and coverage info via My Account (if you do not have an account select the "Create an Account" link).

www.uhcsr.com

Pre-Certification Requirements

AdvoCare
800-525-8548

Enrollment, Eligibility, and Continuation Plan

GU Student Health Insurance Office
Georgetown University, 31 Henle Village
Washington, DC 20057-1101
202-687-4883, 202-687-4955 (fax)
<http://studentaffairs.georgetown.edu/insurance>
8:30 a.m. to 4:30 p.m. (EST)

Premium Payments are sent to Student Accounts and made payable to Georgetown University

Georgetown University
Department 0717
Washington, DC 20073-0717

ACCESSING THE PROVIDER NETWORKS

Student Health Center (SHC)

Darnall Hall, Ground Floor
3800 Reservoir Rd., NW
Washington, DC 20007
202-687-2200 (for appointments)
202-687-3100 (for immunizations)

Counseling and Psychiatric Service (for appointments/information)

Counseling & Psychiatric Services
1 Darnall Hall, 37th and O Street, NW
Washington, DC 20057
202-687-6985

Urgent After Hours Medical & Mental Health Advice

202-444-PAGE

Georgetown University Hospital Referral Line

Inside Metro D.C. 202-342-2400
Outside Metro D.C 866-745-2633

Collegiate Assistance Program

1-877-643-5130

(24 hour medical advice)

**UnitedHealthcare Options PPO Network
UnitedHealthcare Network Pharmacy**

1-877-935-5437 or www.uhcsr.com
1-877-417-7345 or www.uhcsr.com

**Scholastic Emergency Services
Global Emergency Medical Assistance**

within US 877-488-9833
outside US 609-452-8570 (collect)
www.assistamerica.com

**HEALTH INSURANCE FOR STUDENTS
of
GEORGETOWN UNIVERSITY**

2009 - 2010



Please keep this brochure as a general summary of the insurance. The Master Policy 2009-32-1 on file at the University, contains all of the provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between the brochure and policy, the Master Policy will govern and control the payment of benefits.

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

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INTRODUCTION

For all students, good health is essential to achieving educational goals. Maintaining good health requires access to health care when you need it. In the United States, each person is financially responsible for his or her health care, and access to health care may be affected by one's ability to pay. Many people would not be able to pay for their health care without the help of health insurance.

Unfortunately, for many people health insurance is becoming increasingly difficult to obtain. In the United States today, approximately 47 million people have no health insurance¹. A large percentage of these uninsured are self-employed or work for small businesses and do not have access to group insurance policies. Often they cannot afford the high cost of individual policies or even obtain access to one.

Not surprisingly, students, who often lack access to employer-funded group plans and who typically cannot afford individual policies, comprise one of the largest groups of uninsured people in the country. Making the situation worse, many employer-funded group health plans have lowered the age at which a student can qualify as a dependent on a parent's plan. Uninsured students risk having their access to health care limited and their education interrupted by the financial burdens of an unexpected accident or illness.

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

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

Because so many students have difficulty obtaining comprehensive, affordable coverage on their own, the University has accepted the responsibility of obtaining an affordable plan for its students, the Premier Plan. Students who are eligible for insurance in the fall are automatically charged for the Premier Plan. Students who already have coverage of at least \$100,000 per Injury and per Sickness, may waive the Premier Plan by supplying documentation of insurance coverage on a waiver form.

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

The University has worked with Gallagher Koster to develop a health insurance policy tailored to the health needs and financial capabilities of students. UnitedHealthcare Insurance Company underwrites the Plan.

¹ U.S. Census Bureau, 2006

ENROLLMENT PROCEDURES

Enrollment Requirements

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

Tuition Statement

All eligible students are charged \$1,700 for insurance in the fall semester. Students who become eligible for the Plan for the first time in the spring semester are charged \$1,099 for spring coverage. Upon accepting or waiving enrollment in the Plan, students should not assume that their tuition bill or student account balance includes a corresponding charge or credit for insurance.

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

ONLINE MyACCESS+ ENROLLMENT

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

The online enrollment system is available through September 15, 2009, for the fall enrollment and through January 30, 2010, for the spring. Only a few students become eligible to enroll in the spring.

If You Wish to Accept

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

If you receive health care, and you have not submitted an acceptance election, submit it immediately so providers can be paid promptly for their services and your prescription card can be activated.

If You Wish to Waive

If you already have health insurance coverage of at least \$100,000 per Injury and \$100,000 per Sickness, which will remain in effect throughout the academic year, you may waive participation in the Plan by submitting documentation of other insurance. Please log onto the website, review the health insurance information, and click on "Online Acceptance/Waiver". The effective date of the other insurance must be prior to September 15, 2009, for fall waivers and, February 1, 2010, for spring waivers. The fall deadline for the submission of waivers is September 15; the spring deadline for the submission of waivers is January 31, 2010. Students who do not submit their waivers by these deadlines will be charged a \$100 late fee.

Online MyAccess+ Enrollment continued

All waivers are subject to approval by the GU Student Health Insurance Office. If you are eligible in the fall and waive the insurance, you will receive on your student account a \$1,700 insurance credit that applies the waiver to the entire 12-month term. If you are eligible in the spring and waive the insurance, you will receive on your student account a \$1,099 insurance credit that applies the waiver to the remaining 7.5 months of the term. The checklist for Health Insurance Coverage below can assist you in determining whether your current coverage is adequate.

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

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

CHECKLIST FOR HEALTH INSURANCE COVERAGE

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

• Coverage in the Washington Area

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

• Club Sports Coverage

Students who participate in sports programs should have health care coverage. Intercollegiate or professional sports injuries are not covered under this plan. This plan does cover specific GU club sports injuries. Refer to page 21 for information on club sports coverage or call Gallagher Koster for a more detailed description.

• Study Abroad and Worldwide Coverage

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

Checklist for Health Insurance Coverage continued

• Mental Health Care Benefits

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

• Insured's Payment Obligations

The Georgetown University Student Health Center (SHC) charges students for visits. Parents and students should make certain that their deductibles and coinsurance would not preclude them from obtaining appropriate health care services. A description of our plan's deductible and other payment obligations is included in the Schedule of Benefits Summary on page 12-15.

• Full-Time / Part -Time

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

• Dual Coverage Under This Plan and Another Plan

You may want to remain covered under your current plan and purchase this Plan. However, this Plan would not necessarily be your primary plan. This Plan coordinates benefits with other plans to determine which plan pays first. Refer to the Coordination of Benefits explanation on page 29, if you wish to be covered under this Plan and another.

STUDENT ELIGIBILITY AND ENROLLMENT

Coverage is available to students in a degree program who are registered at Georgetown University (for purposes other than enabling plan eligibility) for nine or more credit hours, or for Thesis Research, or Law and Graduate Students registered for eight or more credit hours and are actively attending classes or completing other required academic work. The following groups of individuals are also designated as eligible for the Plan: "Psychology Associates" within CAPS and "Ophthalmology Assistant Trainees" within the Department of Ophthalmology.

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

- Students who were enrolled in the health plan for GU students (whose coverage expired August 15, 2009), who are enrolled in a degree program, and who have reduced their credit hours to part-time (less than nine) due to sickness or injury.
- Students who were enrolled in the health plan for GU students (whose coverage expired August 15, 2009), and who have been granted a medical leave of absence, not to exceed 2 years.

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

Student Eligibility and Enrollment continued

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

Student Enrollment Period

The enrollment period is a limited time period at the beginning of each Plan year or semester when an eligible student may purchase coverage and become covered under the Plan. Coverage must be renewed at the beginning of each Plan year. Students renewing a policy will have continuous coverage if they enroll and pay the premium during the prescribed enrollment period. The enrollment period for the 2009-2010 Plan year begins July 1, 2009, and ends September 15, 2009. Eligible students who enroll during this enrollment period will be covered from August 15, 2009, through August 14, 2010.

Eligible students who wish to enroll in the Plan for the first time or who are returning after a break in enrollment must enroll during the fall enrollment period. Students who are not eligible to enroll in the fall, but are eligible to enroll in the spring, may enroll during the spring enrollment period which begins January 1, 2010, and ends January 31, 2010. The coverage period for such students will become effective on January 1, 2010, and will remain in effect through August 14, 2010. If a student does not enroll within these required time periods, the student must wait to enroll until the next enrollment period (subject to the Late Enrollment provisions described below).

Late Enrollment

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

DEPENDENT ELIGIBILITY AND ENROLLMENT

Eligible students who enroll may also insure their dependents. Eligible dependents are the legal spouse and unmarried children under 19 years of age who are not self-supporting. Dependent eligibility expires concurrently with that of the insured student. No one will be eligible as a dependent while covered as a student (a student cannot be covered twice under the Plan) or while in active military service. A child who is physically or mentally incapable of self-support upon attaining age 19 may continue under the Plan as long as he or she remains incapacitated and unmarried and the student's own coverage continues. UnitedHealthcare Insurance Company may request proof of incapacity from time to time.

Dependent Eligibility and Enrollment continued

Dependent Enrollment Period

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

The date of the dependent's coverage will be:

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

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

Change in Family Status Notification

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

POLICY PERIOD AND PLAN COSTS

Coverage will be in effect on August 15, 2009, through August 14, 2010, for students who enroll during the fall enrollment period. For students who enroll in the spring, coverage will become effective on January 1, 2010, through August 14, 2010.

	<u>Annual*</u>	<u>Spring Semester*</u>
Student Only	\$ 1,700.00	\$ 1,099.00
Student & Spouse	\$ 5,319.00	\$ 3,371.00
Student & All children	\$ 5,319.00	\$ 3,371.00
Family	\$ 8,920.00	\$ 5,629.00

* Includes a \$82 Georgetown University Administrative Fee.

This is a non-renewable one year term policy.

PREMIUM REFUND POLICY

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

The Plan for students and dependents will terminate on August 14, 2010. Any Covered Person who is called into active duty into the armed forces of any country will be terminated from the Plan and will receive a pro-rated refund upon notifying the GU Student Health Insurance Office.

Withdrawals from School

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

1. If an unexpected Sickness or Injury occurs within the first 31 days forcing the student to withdraw from classes; and a medical leave of absence is granted by the Dean, he or she may be covered for the remainder of the Plan year. In this case, a medical release must be granted by the Medical Director of either The Student Health Center (SHC) or Counseling and Psychiatric Service (CAPS). Students who intend to pursue this option should contact the appropriate Medical Director within this 31-day period. If the student wishes to terminate his or her coverage, a full refund will be issued upon notifying the GU Student Health Insurance Office, provided no claims have been submitted.
2. If a student, who was enrolled in the prior GU Plan (whose coverage expired August 15, 2009), is forced by Sickness or Injury to withdraw from classes; and a medical leave of absence is granted by the Dean, he or she may be covered for the remainder of the Plan year. In this case, a medical release must be granted by the Medical Director of either the SHC or CAPS. Students who intend to pursue this option should contact the appropriate Medical Director within this 31 day period. Under no circumstances will the company recognize a medical leave greater than an aggregate leave of two years during the entire time the student is insured by the company. If the student wishes to terminate his or her coverage, a full refund will be issued upon notifying the GU Student Health Insurance Office, provided no claims have been submitted.
3. Students who withdraw from the University for non-medical reasons, or who are not granted a medical leave of absence during the first 31 days of the semester, are not eligible for the Plan. Students must notify the GU Student Health Insurance Office (202-687-4883) of such withdrawal and the entire cost of the coverage for that enrollment period (including dependent coverage) will be credited to the student's account. Such a student will not be entitled to any benefits from the 2009-2010 GU Student Health Insurance Plan and no claims will be honored.

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

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

DEFINITIONS

Covered Medical Expenses or Covered Expenses means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; and 5) in excess of the amount stated as a Deductible.

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

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

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

Hospital Confined/Hospital Confinement means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

Injury means bodily injury which is: 1) directly and independently caused by contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; and 3) a source of loss. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

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

Medical Emergency means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in: 1) Death; 2) Placement of the Insured's health in jeopardy; 3) Serious impairment of bodily functions; 4) Serious dysfunction of any body organ or part; or 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

Definitions continued

Medical Necessity means those services or supplies provided or prescribed by a Hospital or Physician which are: 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; and, 5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 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 Hospital Confinement.

The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by Group Policy.

Mental and Nervous Disorder means a Sickness that is a mental, emotional or behavioral disorder. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the (International Classification of Diseases) are considered one Sickness.

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

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

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

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

Sickness means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness.

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

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

PROVIDER NETWORKS

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

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

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

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

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

Preferred Providers

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

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

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

SCHEDULE OF BENEFITS FOR SCHEDULES 1, 2, AND 3

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

Benefit payments are determined based on where services are provided and who provides the service. Schedules 1, 2 and 3 are available to all students who enroll in the Plan. Schedules 2, and 3 are available to all dependents who enroll in the Plan. Generally, out-of-pocket expenses are lowest when you access providers under Schedule 1-first; 2-second and 3-third. The Schedule of Benefits Summary on pages 12-15 sets forth the benefits available under each of these schedules.

Schedule 1

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

Special SHC Benefits

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

Referrals Required for Other Special Benefits

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

SHC referrals are required for the following special benefits:

- Nutritional counseling by a Georgetown University Health Education certified nutritionist to be paid at 100% of Preferred Allowance;
- Outpatient Physical Therapy; benefits are paid at 80% of Preferred Allowance after the Deductible is applied (Schedule 2); and 70% of the Usual and Customary Charges after the Deductible is applied (Schedule 3) for 2 visits/week with a 6 week maximum when referred by the SHC or the GUH Orthopedic Department; Limited to one visit per day. Page 13 for additional Physical Therapy benefits associated with Surgery and Hospital Confinement.
- Sleep disorders to be paid at 80% of Preferred Allowance after the Deductible and Co-payment are applied (Schedule 2); and 70% of the Usual and Customary Charge after the Deductible is applied (Schedule 3);and
- Allergy testing requires an SHC referral and pre-certification by AdvoCare. After the Deductible, the Preferred Provider reimbursement is 70% of the Preferred Allowance; the Out-of-Network reimbursement is 60% of Usual and Customary Charge. Treatment of allergies are Covered Expenses only when provided at the SHC except for follow-up visits needed as a result of the testing, which require an SHC referral and an AdvoCare pre-certification.

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

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

- Psychological testing to determine learning disabilities, paid at 100% up to \$750 Lifetime Maximum benefit (policy Deductible does not apply).

Schedule 2

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

Schedule 3

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

Schedule of Benefits Summary

PA = Preferred Allowance U&C = Usual & Customary Charges Max = Maximum

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

	Schedule 1	Schedule 2	Schedule 3
Provider Network	Student Health Center (SHC) and Counseling & Psychiatric Care Service (CAPS). Subject to Availability	Preferred Providers: Georgetown University Hospital (GUH), UnitedHealthcare Options PPO Network	Out-of-Network Providers, including Out of Country Providers
Deductible per Policy Year	No Deductible	\$200 per Student* / \$600 per Family*	\$250 per Student* / \$600 per Family*
Combined Maximum Benefit: For all schedules per Injury or Sickness per policy year.	\$280,000		
OUTPATIENT EXPENSES			
Physician Visit Expense: Includes well visits, routine GYN, and Physical Exams. Benefits for Physician's Visits do not apply when related to same day surgery and Physiotherapy.	100% of PA; \$15 Copay for routine GYN and Physical Exams and Special SHC Benefits,\$10 copay for other visits	100% of PA; \$10 Copay office visit; \$20 Copay, Specialist visit; \$30 Copay, Routine GYN & Physical Exams*	70% of U&C*
Day Surgery Miscellaneous Expense: In conjunction with scheduled surgery performed in a Hospital. Includes operating room expense, laboratory tests & diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines, & Supplies. Usual and Customary charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility charge Index.	Not Available	80% of PA*	70% of U&C*
Surgeon and Assistant Surgeon's Fees Expense; For limitations on multiple surgeries, see page 28.	Not Available	80% of PA*	70% of U&C*
Anesthetist Expense, professional services administered in connection to surgery.	Not Available	80% of PA*	70% of U&C*

OUTPATIENT EXPENSES	Schedule 1 SHC & CAPS	Schedule 2 GUH & UHC PPO Network	Schedule 3 Out-of-Network & Out of Country
Physiotherapy (Physical Therapy) for a condition that required surgery or Hospital Confinement, within the 30 days after the surgery or release from the Hospital or within the 30 days following the attending Physician's release for rehabilitation. Limited to one visit per day.	Not Available	80% of PA*	70% of U&C*
Physiotherapy (Physical Therapy) Other , with referral from SHC or the GUH Orthopedic Department. Limited to one visit per day.	Not Available	80% of PA* / up to 2 visits / week up to max of 6 weeks	70% of U&C* / up to 2 visits / week up to max of 6 weeks
Diagnostic X-ray & Laboratory Services Test & Procedures Expense: Includes Diagnostic services and medical procedures performed by a Physician, other than Physician's Visits.	100% of PA when billed by SHC. Available services are limited.	80% of PA*	70% of U&C*
Medical Emergency Expense: The Copayment is waived if hospitalized. Includes attending Physician's charges, laboratory and testing in addition to the use of the emergency room and supplies.	Not Available	After a \$100.00 copay & applicable Deductible, 100% of PA*	After a \$100.00 copay & applicable Deductible 100% of U&C*
Injections , when administered in the Physician's office and charged on the Physician's statement.	100% of PA	80% of PA*	70% of U&C*
Radiation & Chemotherapy Expenses	Not Available	80% of PA*	70% of U&C*
Mental and Nervous Disorder , The deductible does not apply under Schedules 1 and 2. AdvoCare Pre-Certification is required after the 6th visit under Schedules 2 and 3; refer to page 16 for AdvoCare Pre-Certification procedure. The combined inpatient and outpatient lifetime maximum benefit is \$95,000. <i>Limited to one visit per day except when a medication management visit is also necessary.</i>	After a \$5.00 copay per office visit 100% of PA	Visits 1-40 are covered at 75% of PA; thereafter, all visits are covered at 60% of PA. See Benefits for Mental & Nervous Disorder, Alcoholism & Drug Dependency	Visits 1-40 are covered at 75% of U&C*; thereafter, all visits are covered at 60% of U&C. See Benefits for Mental & Nervous Disorder, Alcoholism & Drug Dependency
Alcoholism and Drug Dependency: The Deductible does not apply under Schedules 1 and 2. AdvoCare Pre-Certification is required after the 6th visit under Schedules 2 and 3; refer to page 16 for AdvoCare Pre-Certification procedure.	After a \$5.00 copay per office visit 100% of PA	75% of PA for 1-40 visits; thereafter 60% of PA per policy year. See Benefits for Mental & Nervous Disorder, Alcoholism & Drug Dependency	75% of U&C* for 1-40 visits; thereafter 60% of U&C per policy year. See Benefits for Mental & Nervous Disorder, Alcoholism & Drug Dependency

INPATIENT	Schedule 1 SHC & CAPS	Schedule 2 GUH & UHC PPO Network	Schedule 3 Out-of-Network & Out of Country
INPATIENT EXPENSES (PreCertification Required for Inpatient Admissions)			
Physician Visit Expense: Benefits do not apply when related to surgery.	100% of PA*	80% of PA*	70% of U&C*
Surgeon and Assistant Surgeon's Fees Expense; for limitations on multiple surgeries, see page 28.	Not Available	80% of PA*	70% of U&C*
Anesthetist Expense, professional services administered in connection to surgery.	Not Available	80% of PA*	70% of U&C*
Pre-admission Testing Expense, This benefit is payable within 3 days prior to admission.	Not Available	80% of PA*	70% of U&C*
Hospital Expense: Includes daily semi-private room rate and general nursing care provided by the Hospital. Hospital Miscellaneous Expenses include the cost of the operating room, laboratory test, x-ray examinations, anesthesia, drugs (excluding take home), medicines, therapeutic services, or supplies.	Not Available	80% of PA*	70% of U&C*
Registered Nurse Expense	Not Available	80% of PA*	70% of U&C*
Intensive Care Unit/Hospital Expense	Not Available	80% of PA*	70% of U&C*
Skilled Nursing Facility Visit Expense	Not Available	80% of PA*	70% of U&C*
Physiotherapy (Physical Therapy)	Not Available	80% of PA*	70% of U&C*
Mental and Nervous Disorders: The Deductible does not apply. The combined inpatient and outpatient lifetime max benefit is \$95,000.	Not Available	80% of PA up to 60 days per policy year. See Benefits for Mental & Nervous Disorder, Alcoholism & Drug Dependency	70% of U&C up to 60 days per policy year. See Benefits for Mental & Nervous Disorder, Alcoholism & Drug Dependency
Alcoholism and Drug Dependency: The Deductible does not apply.	Not Available	80% of PA up to 60 days per policy year / See Benefits for Mental & Nervous Disorder, Alcoholism & Drug Dependency	70% of U&C up to 60 days per policy year / See Benefits for Mental & Nervous Disorder, Alcoholism & Drug Dependency
OTHER			
Allergy Testing: Please refer to Exclusion #1. SHC referral and AdvoCare precertification required. Any follow up visits to testing will be paid under Physician's Visits as a Specialist.	Not Available	70% of PA*	60% of U&C*

OTHER CONTINUED	Schedule 1 SHC & CAPS	Schedule 2 GUH & UHC PPO Network	Schedule 3 Out-of-Network & Out of Country
Ambulance Services	Not Available	80% of PA*	70% of U&C*
Durable Medical Equipment (non-replacement Braces & Appliances): Includes prosthetic devices. A written prescription must accompany claim.	Not Available	80% of PA*	70% of U&C*
Consultant Physician Fees: When requested by attending Physician. Includes services rendered by GU Health Education Certified Nutritionist.	Not Available	80% of U&C*	70% of U&C*
Dental Treatment: Includes treatment to sound, natural teeth when made necessary by injury.	Not Available	80% of U&C*	80% of U&C*
Immunizations/Vaccines: (See Exclusion # 13, page 26).	After a \$15 copay, 100% of PA	Excluded	Excluded
Complications to Non-Covered Services	\$10 copay, 100% of PA	80% of PA*	70% of U&C*
Maternity/Complications of Pregnancy:	Not Available	80% of PA*	70% of U&C*
Routine Well-Baby Care: Includes well-baby visits and immunizations for the first 2 years of a Covered Dependent's Life. See Mandated Benefits for Child Health Screening Services for additional child benefits.	Not Available	80% of PA*	70% of U&C*
Home Health Care: Includes maximum of 90 days per Policy Year.	Not Available	80% of PA*	70% of U&C*
Hospice Care: The policy deductible does not apply.	Not Available	80% of PA	70% of U&C
Speech Therapy: Includes maximum of 20 visits per Policy year.	Not Available	80% of PA*	70% of U&C*
Prescription Drugs: \$5,000 per policy year maximum per covered person. (See page 19)	Not Available	Prescriptions should be filled at a UnitedHealthcare Network Pharmacy. \$10 copay for up to 31 day supply of a Tier 1 prescription; \$25 copay up to 31 day supply of a Tier 2 prescription; or \$45 copay up to 31 day supply of a Tier 3 prescription.	
Learning Disability Testing: Services only provided for testing when referred by the designated Georgetown Learning Disability Coordinator (refer to Exclusion #3).	Not Available	100% of PA / up to a combined Lifetime maximum of \$750	100% of U&C / up to a combined Lifetime maximum of \$750

* Deductible Applies

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

SCHEDULE OF BENEFITS PRE-CERTIFICATION REQUIREMENTS

Pre-Certification for Hospital Admissions

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

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

To obtain Pre-Admission Certification:

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

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

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

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

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

Pre-Certification for Outpatient Mental and Nervous Disorders, Alcoholism and Drug Dependency

Pre-Certification must be obtained in order to receive the maximum benefit payable for Outpatient Mental and Nervous Disorders, Alcoholism, and Drug Dependency. A Pre-Certification is a pre-treatment review by AdvoCare of the Medical Necessity of Mental and Nervous Disorders, Alcoholism, and Drug Dependency. Pre-Certification must be obtained after the sixth outpatient visit when treatment is received under Schedule 2 or Schedule 3. Pre-Certification may be obtained by calling AdvoCare.

The Insured Person is responsible for obtaining Pre-Certification and informing the Physician that the Insured Person is a participant in a program that has Pre-Certification requirements. Pre-Certification does not guarantee benefits.

To obtain Pre-Certification:

1. AdvoCare must be provided with information necessary to make a decision as to the Medical Necessity of the treatment; and
2. AdvoCare must be informed no later than three days prior to the seventh visit. Notice can be given by: (a) the Physician; or (b) the Insured Person.

When Pre-Certification is provided to the Insured Person, a certain length of treatment for the service will be assigned. During the treatment a continued treatment review will be conducted and extensions to the initial treatment plan will be viewed for Medical Necessity. If services are not determined to be Medically Necessary during pretreatment review or continued treatment review, the Insured Person and the Physician will be notified and no payment will be made for services determined to be not Medically Necessary. If pretreatment or continued treatment review is not obtained, a retrospective review of services will be completed prior to payment. If, after retrospective review, it is determined that services were Medically Necessary, payment of benefits for Physicians and Hospitals charges will be reduced by 50% of Covered Expenses. This is referred to as a "penalty". This penalty will not be applied toward any Deductible, Coinsurance or Out-of-Pocket Maximum.

If the retrospective review reveals that the services were not Medically Necessary, the Insured Person and the Physician will be notified and no payment will be made for those services determined to be not Medically Necessary.

Pre-Certification for Allergy Testing

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

Certification of Medical Emergency Admissions

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

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

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

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

Certification of Maternity Admissions

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

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

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

Maternity admissions are admissions to Hospitals expressly for giving birth.

Additional Hospitalization Reviews

Additional Hospitalization reviews include:

- During an Insured Person's Hospital stay, AdvoCare continues to review the Hospital stay. This does not apply to maternity admissions except if the stay is greater than two days. The purpose of continued reviews is to obtain updates as to an Insured Person's progress and, if necessary, to enable AdvoCare to reevaluate the Medical Necessity of a continued Hospital stay.
- All weekend (Friday and Saturday) Hospital admissions are reviewed. Coverage is limited to Medically Necessary admissions.
- Review for discharge planning is also conducted. Discharge planning identifies patients who require extended care following a discharge. Discharge planning also determines the most appropriate setting for continued care.

SCHEDULE OF BENEFITS OUT-OF-POCKET EXPENSES

Maximum Benefits

The Policy provides medical benefits for the Usual and Customary Charge (U & C) incurred by a Covered Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of \$280,000 for each Injury or Sickness per Policy Year.

The maximum Prescription Drug benefit for Insured Persons is \$5,000 per policy year.

The combined maximum lifetime benefit for inpatient and outpatient Mental and Nervous Disorders is \$95,000.

The Deductible

The Deductible is the amount you pay each Plan year for certain Covered Expenses before the Plan will pay any further expenses. It applies to any individual covered by the Plan. You satisfy the Deductible just once each Plan year, even if you have several different kinds of expenses. Coinsurance and Co-payments count toward the Deductible under any schedule. See the Schedule of Benefits Summary on pages 12-15.

There is no deductible for coverage under Schedule 1. The Deductible under Schedule 2 is \$200 per person not to exceed \$600 per family per Plan year and the Deductible under Schedule 3 is \$250 per person not to exceed \$600 per family per Plan year.

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

The Co-payments

A Co-payment is a fixed dollar amount that you must pay each time you receive certain Covered Expenses as indicated in the Schedule of Benefits Summary on pages 12-15. For example, Physician visits, Emergency Room visits, and Prescriptions have Co-payments.

Coinsurance

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

Limits on Your Out-of-Pocket Expenses

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

SCHEDULE OF BENEFITS FOR ADDITIONAL INJURY AND SICKNESS COVERED EXPENSES

Accidental Death & Dismemberment

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 365 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below. Payment under the benefit when added to payment under the Schedule of Benefits shall not exceed the policy Maximum Benefit.

For Loss of:

Life	\$5,000.00
Two or More Members	\$2,500.00
One Member	\$1,250.00

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

Home Health Care

Benefits are provided for certain services furnished by a Home Health Care Agency. Under Schedule 2, the Plan pays 80% of Preferred Allowance. Under Schedule 3, the Plan pays 70% of Usual and Customary Charges. The combined maximum benefit is 90 days per policy Year.

Maternity Expense

If a Covered Person is pregnant, We will pay for any Medically Necessary expenses for prenatal care, childbirth and postpartum care. Expenses for childbirth include hospital inpatient care of not less than 48 hours following a vaginal delivery or not less than 96 hours following a cesarean section, unless the attending Physician, in consultation with the mother makes a decision for an earlier discharge from the hospital. Coverage for Maternity Testing Expense is limited; please refer to page 28.

Collegiate Assistance Program

Insured Students have access to nurse advice and health information 24 hours a day, 7 days a week by dialing 1-877-643-5130. Collegiate Assistance Program is staffed by Registered Nurses who can help students determine if they need to seek medical care, understand their medications or medical procedures, or learn ways to stay healthy.

Prescription Drug Program

UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits (up to 31 days) and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are a few Prescription Drugs that require your Physician to notify us to verify their coverage within your benefit.

You are responsible for paying the applicable copayments. Your copayment is determined by the tier to which the Prescription Drug is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 1-877-417-7345 for the most up-to-date tier status.

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

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

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

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

Your maximum allowed benefit is \$5,000 per policy year.

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

If you do not present the card, you will need to pay the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, to enroll in mail order, or for information about network pharmacies, please visit www.uhcsr.com and log in to your online account or call 1-877-417-7345.

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

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

Definitions

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

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

Routine Well Baby Coverage

Coverage for the newborn includes care and treatment of medically diagnosed congenital defects and birth abnormalities. Routine nursery care for the well newborn is covered. Inpatient medical service visits to examine the well newborn are also covered. Outpatient well baby care and related medical tests or examinations and other medical services are covered for the first two years of the covered dependents life. See page 6 for more details on enrollment of Newborns and see page 24 for mandated benefits for Child Health Screening Services.

Temporomandibular Joint Disorder and Craniomandibular Disorder

Benefits shall be provided, on the same basis as benefits for treatment to any other joint in the body, for diagnostic and surgical treatment of temporomandibular joint disorder and craniomandibular disorder. Treatment may be administered or prescribed by a Doctor or dentist. This coverage will not exceed a \$10,000 maximum lifetime benefit.

CLUB SPORTS

Coverage of club sports injuries is limited to \$25,000 per injury per plan year by UnitedHealthcare Insurance Company. After the \$25,000 maximum benefit under UnitedHealthcare Insurance Company has been paid, AIG will cover injuries sustained while participating in the following GU club sports: soccer, lacrosse, rugby, softball, water polo, volleyball, field hockey, ice hockey, ultimate frisbee, triathlon, racquetball, squash, baseball, basketball, tennis, cycling, running, boxing and equestrian according to the policy terms and limitations as described under the AIG Catastrophic Club Sports Policy. The AIG policy will pay up to \$5 million dollars of covered expenses incurred within five years of the injury. Neither UnitedHealthcare Insurance Company nor AIG covers injuries sustained while participating in intercollegiate or professional sports, see Exclusion 15.

Catastrophic Cash Benefits

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

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

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

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

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

LUMP SUM: Payable at the end of the Waiting Period. \$750,000 Lump Sum, then \$75,000 per year for 30 years.

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

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

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

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

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

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

This plan is not underwritten by UnitedHealthcare Insurance Company.

This plan is underwritten by AIG.

BASIX DENTAL SAVINGS AND WELLNESS SUPPORT PROGRAM

The cost of dental care is a major concern to both students and health service administrators. To help with this issue, Gallagher Koster Insurance makes the Basix Dental Savings Program available to you. It is important to understand the Dental Savings Program is not dental insurance. Basix contracts with dentists that agree to charge a reduced fee to students covered under the Premier Plan. The student must pay for the services received at the time of service to receive the negotiated rate.

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

- Make an appointment with a contracted dentist; all the contracted dentists are listed on our website, www.basixstudent.com.
- Make sure the dental office understands that you have access to the Basix program. We list an administrative contact person for each dentist to help clear up any confusion on the spot. We don't issue a separate identification card for the Basix program. The dentist's office may ask for your health plan identification card to make sure you have access to the program. If the office needs to check eligibility, call Gallagher Koster at 800-457-5599.
- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

College health is all about helping to develop healthy habits. Our program supports those efforts by making available free downloadable mp3 files.

- Need some exercise? Download one of a dozen stationary bike workouts that range from an easy introduction to a simulated criterium road race. Coached walking routines and treadmill routines are also available.
- Need some sleep? Try one our eight guided imagery and Qigong relaxation downloads.
- Need help with weight management? We have two mp3 files specifically designed to help you maintain a healthy weight, one specifically dealing with the "Freshman 15".

Full details of the program can be viewed at the website: www.basixstudent.com. Once at the home page, select the link for your school. You may also contact us via email from our website, or by telephone at (888) 274-9961.

This plan is not underwritten by UnitedHealthcare Insurance Company.

SCHOLASTIC EMERGENCY SERVICES: GLOBAL EMERGENCY MEDICAL ASSISTANCE

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

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

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

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

Key Services include:

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

Please visit www.gallagherkoster.com or your school's insurance coverage page at www.uhcsr.com for the Scholastic Emergency Services Global Emergency Medical Assistance brochure which includes service descriptions and program exclusions and limitations.

To access services please call: **(877) 488-9833** Toll-free within the United States or **(609) 452-8570** Collect outside the United States

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

When calling Assist America's Operations Center, please be prepared to provide:

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

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

MANDATED BENEFITS

Benefits for Mental & Nervous Disorder, Alcoholism and Drug Dependency

Benefits will be paid the same as any other Sickness for Mental and Nervous Disorder, Alcoholism and Drug Dependency subject to all terms and conditions of the policy and the following limitations.

Covered Medical Expenses will be limited to inpatient, residential, and outpatient services provided by a Hospital, non-hospital residential facility, outpatient treatment facility, Physician, psychologist or independent clinical social worker. Before an Insured may qualify to receive benefits under this benefit, a Physician, psychologist or independent clinical social worker must: 1) certify that the individual is suffering from drug abuse, alcohol abuse or a Mental and Nervous Disorder; 2) certify that the treatment is medically or psychologically necessary; and 3) prescribe appropriate treatment which may include referral to other treatment providers.

Covered Medical Expenses will be limited to coverage of treatment of clinically significant substance use disorders or mental illness identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Benefits will be paid not to exceed a maximum of 12 days per policy year for the process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum. Additional treatment for alcoholism and drug dependency will be provided not to exceed 60 days per policy year for inpatient or residential care, and for a maximum of 75% for the first 40 outpatient visits per policy year and at maximum rate of 60% for any outpatient visits thereafter for that policy year.

Benefits will be paid for the treatment of Mental and Nervous Disorders not to exceed a maximum of 60 days per policy year for inpatient or residential care, and for a maximum of 75% for the first 40 outpatient visits per policy year and a maximum rate of 60% for any outpatient visits thereafter for that policy year. The inpatient and outpatient benefits for Mental and Nervous Disorders will not exceed a maximum lifetime benefit of \$95,000 or one third of the maximum lifetime benefit for any other Sickness, whichever is greater.

Benefits shall be subject to all Deductible, co-payment, coinsurance, limitations, or any other provisions of the policy; except as specifically provided in the Schedule of Benefits.

Benefits for Child Health Screening Services

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

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

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

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

Benefits will be paid the same as any other Sickness for habilitative Services for the treatment of Congenital or Genetic Birth Defects.

For the purposes of this benefit:

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

Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects (continued)

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

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

Benefits for Diabetes

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

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

Benefits for Postpartum Care

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

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

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

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

Benefits for Colorectal Cancer Screening

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

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

Benefits for Cytologic Screening and Mammographic Examinations

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

Benefits for Prostate Cancer Screening

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

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

EXCLUSIONS AND LIMITATIONS

Exclusions

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

1. Acupuncture; allergy, including allergy testing; except for Special Benefits provided at SHC (see page 11);
2. Services and supplies related to nicotine addiction;
3. Services and supplies for conditions related to learning disabilities, except for learning disabilities testing, when referred by the designated Georgetown Learning Disability Coordinator, up to a \$750 per lifetime maximum;
4. Biofeedback or services and supplies related to biofeedback;
5. Circumcision, except for Newborn Infants;
6. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Policy or for newborn or adopted children;
7. Dental treatment, except for Injury to sound, natural teeth;
8. Elective Surgery or Elective Treatment or Elective Abortion, except as specifically provided for in the Policy;
9. Vision services and supplies related to eye refractions or eye examinations, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses, and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or service except when due to disease process or Injury;
10. Services or supplies for care of corns, bunions (except capsular or bone surgery), or calluses, except for Special Benefits provided at the SHC; **(See page 11)**
11. Hearing examinations or hearing aids; or other treatment for hearing defects and problems except as specifically provided in the Benefits for Child Health Screening Services or except when due to an Injury. "Hearing defects" means any physical defect of the ear that can impair normal hearing, apart from the disease process;
12. Hirsutism, alopecia, warts, non-malignant moles and lesions except for Special Benefits provided at the SHC; **(See page 11)**
13. Immunizations and vaccination services and supplies related to immunizations, except for dependents for the first two years of a covered dependent's life, or as specifically provided in the benefits for Child Health Screening Services, or when provided by the SHC; preventive medicines or vaccines, except where required for treatment of a covered Injury;
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
15. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such intercollegiate or professional sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such intercollegiate or professional sport, contest or competition;
16. Lipectomy services and supplies related to surgical or suction-assisted lipectomy;
17. Organ transplants;
18. Outpatient Physiotherapy, except as specifically provided for in the policy Schedule of Benefits; (See page 13, Physiotherapy and Physiotherapy Other);

19. Patient controlled analgesia (PCA);
20. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:
 - a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; (except as specifically provided under the Benefits for Diabetes);
 - b) Birth control and/or contraceptives, oral or other, whether medication or device; except as specifically provided in the policy;
 - c) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - d) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - e) Products used for unapproved cosmetic purposes;
 - f) Drugs used to treat or cure baldness; anabolic steroids used for body building;
 - g) Anorectics - drugs used for the purpose of weight control;
 - h) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
 - i) Growth hormones; or
 - j) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
21. Participation in a riot or civil disorder, commission of or attempt to commit a felony;
22. Reproductive/Infertility services including but not limited to: birth control; family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception (examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance reproductive ability); premarital examination; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery;
23. Screening exams or testing in absence of Injury or Sickness except for routine physical examinations, gynecological (GYN) visits, or well baby visits under 2 years old, or as specifically provided in the benefits for Child Health Screening Services;
24. Services provided normally without charge by the SHC or services covered or provided by a student health fee;
25. Nasal and sinus surgery; except surgery made necessary as the result of a covered Injury;
26. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, or bungee jumping;
27. Sleep disorders, supplies, treatment, or testing relating to sleep disorders except for services provided at the SHC or when a referral obtained from the SHC accompanies a sleep disorder claim;
28. Supplies, except as specifically provided in the policy;
29. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices;
20. Treatment in a government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
31. War or any act of war, declared or undeclared; or while in the active duty of the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
32. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies; treatment for obesity, surgery for removal of excess skin or fat, except as specifically provided for in the Policy, see page 11 for special SHC referrals;

Limitations

- **Club Sports** - Benefits for loss or expense caused by or resulting from Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with club sports, in excess of \$25,000 per plan year will not be paid by UnitedHealthcare Insurance Company. See page 21 for a Summary of AIG Catastrophic Club Sport Coverage.
- **Maternity Testing** - Certain maternity tests that may be routinely performed by your Doctor may not be covered under this policy. The following maternity routine tests and screening exams will be considered, if all policy provisions have been met: a pregnancy test, CBC, Hepatitis B, Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy without additional diagnosis. Any subsequent Ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following test will be considered for women over 35 years of age: AFP Blood Screening; Amniocentesis/AFP Screening; and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Claims Company at 1-877-935-5437.
- **Multiple Surgeries** - When multiple or bilateral surgical procedures are performed at the same operative session whether through one or more incisions, the Plan will pay for the major or first procedure and in addition, the plan will pay half of the payments otherwise payable for the lesser or subsequent procedures.

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

- **Prescription Drugs** - The maximum Prescription Drug benefit for Insured Persons enrolling is \$5,000.00 per policy year.

CONTINUATION PROVISION

Students and their eligible dependents continuously insured for six (6) consecutive months on or before February 15, 2009, by the Premier Plan for GU students and who have graduated or who otherwise have become ineligible to purchase the Plan in the fall are eligible to continue coverage in this Plan. The continuation coverage is effective August 15, 2009, through February 14, 2010. Enrollment under the Continuation Provision cannot be renewed by the insured.

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

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

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

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

Student Only	\$1,152
Student and Spouse	\$3,402
Student and Child(ren)	\$3,402
Student, Spouse and Children	\$5,676

* Includes a \$82 Georgetown University Administrative Fee.

SUBROGATION/RECOVERY OF BENEFITS

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

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

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

EXTENSION OF BENEFITS AFTER TERMINATION

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

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

COORDINATION OF BENEFITS

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

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

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

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

CONFORMITY TO STATE STATUTES

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

CLAIMS ADMINISTRATION AND PROCEDURES

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

If not satisfied with the outcome, the Insured Persons, Providers or their representative may contact:

For Medical Necessity Appeals:

District of Columbia Department of Health
825 North Capitol Street, 4th Floor
Washington, DC 20002

For All Other Appeals:

District of Columbia Department of Insurance, Securities and Banking
810 First Street NE, Suite 701
Washington, DC 20002

Explanation of Benefits

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

FULLY INSURED DENTAL PLAN

All GU students have access to UnitedHealthcare's Dental plan. Please go to www.uhcsr.com to learn more about the dental plan and print an enrollment form. Select the "Find My School's Plan" link from the College Students area and select your school from the menu.

PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-877-935-5437 or by visiting us at www.uhcsr.com.



GEORGETOWN UNIVERSITY