

# **2017-2018 International Student Injury and Sickness Insurance Plan**

## **Excess Insurance**

Designed Exclusively for International Students

**INTERNATIONAL HEALTH CONSORTIUM SP -  
Georgia International Student Care**

Endorsed for International Students attending

# **Albany State University**

Underwritten by:  
Student Resources (SPC) Ltd.  
A UnitedHealth Group Company  
Administered by  
UnitedHealthcare StudentResources  
PO Box 809025  
Dallas, TX 75380-9025

Market Through:  
PGH Global  
1-888-251-6253

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## Eligibility

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All international students, scholars or other persons with a current passport who: 1) are engaged in educational activities; and 2) are temporarily located outside his/her home country as a non-resident alien; and 3) have not obtained permanent residency status in the U.S. are eligible to enroll in this plan. Those enrolled in an English language or similar program or an Optional Practical Training Program or with an F or J visa are also eligible to enroll in the plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased with the exception of those with a J visa or those engaged in an Optional Practical Training Program. Home study, correspondence and online courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse and dependent children under 26 years of age.

Dependent Eligibility expires concurrently with that of the Insured student.

U.S. citizens are not eligible for coverage as a student or a Dependent.

## Effective and Termination Dates

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The Master Policy becomes effective at 12:01 a.m., August 1, 2017. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., July 31, 2018. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Refunds of premiums are allowed only upon entry into the armed forces.

The Policy is a Non-Renewable One Year Term Policy.

## Extension of Benefits after Termination

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The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is 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 payments be made.

## Pre-Admission Notification

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

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

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

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

## **Preferred Provider Information**

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

UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-251-6253 and/or by asking the provider when making an appointment for services.

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

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

**“Network Area”** means the 50 mile radius around the local school campus the Named Insured is attending.

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

### **Inpatient Expenses**

**PREFERRED PROVIDERS** - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities. Call 1-888-251-6253 for information about Preferred Hospitals.

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

### **Outpatient Hospital Expenses**

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

### **Professional & Other Expenses**

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

## Schedule of Medical Expense Benefits

### Injury and Sickness Benefits

#### Up to a \$250,000 Maximum Benefit (For each Injury or Sickness)

<b>Deductible Preferred Providers</b>	<b>\$100 (Per Insured Person, Per Policy Year)</b>
<b>Deductible Out-of-Network</b>	<b>\$500 (Per Insured Person, Per Policy Year)</b>
<b>Coinsurance Preferred Providers</b>	<b>80% except as noted below</b>
<b>Coinsurance Out-of-Network</b>	<b>70% except as noted below</b>
<b>Out-of-Pocket Maximum Preferred Providers</b>	<b>\$10,000 (Per Insured Person, Per Policy Year)</b>

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

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

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness

**Preferred Provider Out-of-Pocket Maximum:** After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% up to the policy Maximum Benefit subject to any benefit maximums that may apply. The Copays and per service Deductibles, and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. The policy Deductible will be applied to the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays and per service Deductibles.

**Student Health Center Benefits:** The Deductible and Copays will be waived for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Covered Medical Expenses include:

Inpatient	Preferred Provider	Out-of-Network
<b>Room and Board Expense</b> , daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	Preferred Allowance \$100 Copay per Hospital Confinement	Usual and Customary Charges \$100 Deductible per Hospital Confinement
<b>Intensive Care</b>	Preferred Allowance \$100 Copay per Hospital Confinement	Usual and Customary Charges \$100 Deductible per Hospital Confinement
<b>Hospital Miscellaneous Expenses</b> , such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	Preferred Allowance	Usual and Customary Charges

Inpatient	Preferred Provider	Out-of-Network
<b>Routine Newborn Care</b> , while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	Paid as any other Sickness
<b>Physiotherapy</b>	Preferred Allowance	Usual and Customary Charges 30 days maximum
<b>Surgery</b> , if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
<b>Assistant Surgeon</b>	Preferred Allowance	Usual and Customary Charges
<b>Anesthetist</b> , professional services administered in connection with inpatient surgery.	Preferred Allowance	Usual and Customary Charges
<b>Registered Nurse's Services</b> , private duty nursing care.	Preferred Allowance	Usual and Customary Charges
<b>Physician's Visits</b> , non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	Preferred Allowance	Usual and Customary Charges
<b>Pre-admission Testing</b>	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
<b>Surgery</b> , if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
<b>Day Surgery Miscellaneous</b> , related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance \$100 Copay per date of service	Usual and Customary Charges \$100 Deductible per date of service
<b>Assistant Surgeon Fees</b>	Preferred Allowance	Usual and Customary Charges
<b>Anesthetist Services</b> , professional services administered in connection with outpatient surgery.	Preferred Allowance	Usual and Customary Charges
<b>Physician's Visits</b> , benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	Preferred Allowance \$30 Copay per visit	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
<p><b>Physiotherapy</b>, physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.</p>	Preferred Allowance	Usual and Customary Charges
<p><b>Medical Emergency Expenses</b>, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. (The Copay/per visit Deductible will be waived if admitted to the Hospital.)</p>	Preferred Allowance \$100 Copay per visit	80% of Usual and Customary Charges \$100 Deductible per visit
<p><b>Diagnostic X-ray Services</b></p>	Preferred Allowance	Usual and Customary Charges
<p><b>Radiation Therapy</b></p>	Preferred Allowance	Usual and Customary Charges
<p><b>Laboratory Procedures</b></p>	Preferred Allowance	Usual and Customary Charges
<p><b>Tests &amp; Procedures</b>, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.</p>	Preferred Allowance	Usual and Customary Charges
<p><b>Chemotherapy</b></p>	Preferred Allowance	Usual and Customary Charges
<p><b>Prescription Drugs</b>, Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.</p>	UnitedHealthcare Pharmacy (UHCP) \$20 Copay per prescription for Tier 1 30% Coinsurance per prescription for Tier 2 40% Coinsurance per prescription for Tier 3 up to a 31 day supply per prescription	No Benefits

Other	Preferred Provider	Out-of-Network
<b>Ambulance Services</b>	Preferred Allowance	Usual and Customary Charges
<b>Durable Medical Equipment</b> , a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. (\$1,000 maximum Per Policy Year)	Preferred Allowance	Usual and Customary Charges
<b>Consultant Physician Fees</b>	Preferred Allowance \$30 Copay per visit	Usual and Customary Charges
<b>Dental Treatment</b> , made necessary by Injury to Sound, Natural Teeth only. (\$100 maximum per tooth) (\$500 maximum (For each Injury)	Preferred Allowance	80% of Usual and Customary Charges
<b>Mental Illness Treatment</b> , services received on an Inpatient and outpatient basis.	Paid as any other Sickness	Paid as any other Sickness
<b>Substance Use Disorder Treatment</b> , services received on an Inpatient and outpatient basis.	Paid as any other Sickness	Paid as any other Sickness
<b>Maternity</b> , benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.	Paid as any other Sickness	Paid as any other Sickness
<b>Complications of Pregnancy</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Elective Abortion</b> , (\$1,500 maximum Per Policy Year)	Preferred Allowance	Usual and Customary Charges



Other	Preferred Provider	Out-of-Network
<p><b>Preventive Care Services</b>, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; 2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.</p> <p>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. (\$1,000 maximum (Per Policy Year))</p>	100% of Preferred Allowance	No Benefits
<p><b>Reconstructive Breast Surgery Following Mastectomy</b>, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.</p>	Paid as any other Sickness	Paid as any other Sickness
<p><b>Diabetes Services</b>, in connection with the treatment of diabetes for Medically Necessary: 1) outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals; and 2) Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.</p>	Paid as any other Sickness	Paid as any other Sickness
<b>Intercollegiate Sports</b>	See endorsement attached	See endorsement attached

Other	Preferred Provider	Out-of-Network
<b>Urgent Care Center</b> , facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.	Preferred Allowance \$50 Copay per visit	Usual and Customary Charges \$50 Deductible per visit
<b>CAT Scan/MRI</b>	Preferred Allowance \$200 Copay per visit	Usual and Customary Charges \$200 Deductible per visit

## **UnitedHealthcare Pharmacy Benefits**

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments and/or Coinsurance that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable Copayments and/or Coinsurance. Your Copayment/Coinsurance is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access [georgiacare.intlinsure.com](http://georgiacare.intlinsure.com) or call 1-855-828-7716 for the most up-to-date tier status.

\$20 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

30% Coinsurance per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

40% Coinsurance per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

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

**Specialty Prescription Drugs** – if you require Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

**Designated Pharmacies** – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

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 for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit [georgiacare.intlinsure.com](http://georgiacare.intlinsure.com) and log in to your online account or call 1-855-828-7716.

### **Additional Exclusions:**

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.

4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.
6. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
7. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

**Definitions:**

**New Prescription Drug Product** means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

**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 [georgiacare.intlinsure.com](http://georgiacare.intlinsure.com) or call Customer Service at 1-855-828-7716.

**Specialty Prescription Drug Product** means Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products through the Internet at [georgiacare.intlinsure.com](http://georgiacare.intlinsure.com) or call Customer Service at 1-855-828-7716.

**Additional Benefits**

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**Benefits for Drug Treatment of Cancer or Life Threatening Conditions**

When Prescription Drug benefits are payable under the policy, benefits will be provided for drugs for treatment of cancer or life threatening conditions although the drug has not been approved by the Food and Drug Administration for that indication if that drug is recognized for treatment of such indication in one of the standard reference compendia or in the appropriate medical literature. The prescribing Physician must submit documentation supporting the proposed off-label use or uses to the Company if requested. Coverage shall include Medically Necessary services associated with the administration of such drugs.

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

**Benefits for Dental Anesthesia**

Benefits shall be provided for dental anesthesia and related Hospital Covered Medical Expenses for services and supplies provided to a covered Insured Person who:

- (1) Is a child under age five; or
- (2) Is severely disabled or otherwise suffers from a developmental disability as determined by a Physician which places such child at serious risk.

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

## **Excess Provision**

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Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid.

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, this Excess Provision will not be applied to the first \$100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements.

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

## **Accidental Death and Dismemberment Benefits**

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

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

For Loss of:

Life	\$5,000
Two or More Members	\$5,000
One Member	\$2,500
Thumb or Index Finger	\$1,250

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

## **Intercollegiate Sports**

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**Maximum Benefit: \$90,000**  
**(Per Insured Person, Per Policy Year)**  
**Deductible Preferred Providers: \$100 (Per Insured Person, Per Policy Year)**  
**Deductible Out-of-Network: \$500 (Per Insured Person, Per Policy Year)**  
**Coinsurance Preferred Providers: 80% except as noted below**  
**Coinsurance Out-of-Network: 70% except as noted below**  
**Out-of-Pocket Maximum Preferred Providers: \$10,000 (Per Insured Person, Per Policy Year)**

All student athletes who are members of the following intercollegiate athletic teams sponsored by the Policyholder provided that the additional premium of \$1,340 has been paid by the Policyholder: Football, Baseball, Softball, Basketball, Volleyball, Soccer, Cheerleading, Rugby, Golf, Tennis, Rifle, Hockey, Swimming, Track and Field, Equestrian, Wrestling, Boxing, Lacrosse, Gymnastics, and Skating, Cross Country, Rowing, Fencing, Squash, Skiing, Crew, Rodeo, Bowling. The additional premium required is specified on the policy face page.

Subject to a Deductible of \$100 for Preferred Providers / \$500 for Out-of-Network, benefits will be paid for 80% of Preferred Allowance and 70% of Usual and Customary Charges incurred under the Schedule of Benefits for intercollegiate sports Injury up to \$90,000 Per Insured Person, Per Policy Year.

See Policy for Intercollegiate sports exclusions.

The "Excess Provision" does not apply to the coverage provided under this benefit. Benefits for intercollegiate sports Injury will be paid in addition to other insurance.

## Definitions

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

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

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

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

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

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

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

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

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

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

**INJURY** means bodily injury which is all of the following:

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

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

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

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

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

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

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

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

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

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

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

**NEWBORN INFANT** means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

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

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

**PRE-EXISTING CONDITION** means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

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

**USUAL AND CUSTOMARY CHARGES** means the maximum amount the Policy is obligated to pay for services. Except as otherwise required under state or federal regulations, usual and customary charges will be the lowest of:

1. The billed charge for the services.
2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered.
3. An amount determined using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical difference where applicable, plus a margin factor.

The Company uses data from FAIR Health, Inc. and/or Data iSight to determine Usual and Customary Charges. No payment will be made under the Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

## **Exclusions and Limitations**

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

1. Acne;
2. Acupuncture;
3. Addiction, such as: nicotine addiction, except as specifically provided in the policy; and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
4. Biofeedback;
5. Injections;
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. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;
8. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
9. Elective Surgery or Elective Treatment;
10. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
11. Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery);
12. Health spa or similar facilities; strengthening programs;
13. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
15. Injury or sickness outside the United States and its possessions, except when traveling for academic study abroad programs, business or pleasure, or to or from the Insured's home country;
16. Injury or Sickness inside the Insured's home country;
17. Injury or Sickness when claims payment and/or coverage is prohibited by applicable law;
18. Injury sustained while (a) participating in any interscholastic or intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition, unless the additional premium for Intercollegiate Sports Coverage has been paid;
19. Investigational services;
20. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
21. Pre-existing Conditions in excess of \$1,000, except for individuals who have been continuously insured under the student insurance policy for at least 6 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this policy;
22. Prescription Drugs, services or supplies as follows:
  - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;

- Immunization agents, except as specifically provided in the policy., biological sera, blood or blood products administered on an outpatient basis;
  - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
  - Products used for cosmetic purposes;
  - Drugs used to treat or cure baldness; anabolic steroids used for body building;
  - Anorectics - drugs used for the purpose of weight control;
  - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
  - Growth hormones; or
  - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
  24. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;
  25. Routine Newborn Infant Care, well-baby nursery and related Physician charges; in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
  26. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the policy;
  27. Services provided normally without charge by the Health Service of the institution attended by the Insured; or services covered or provided by a student health fee;
  28. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
  29. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
  30. Supplies, except as specifically provided in the policy;
  31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
  32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
  33. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
  34. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, except as specifically provided in the policy.

## **UnitedHealthcare Global: Global Emergency Services**

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

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

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

### **Key Services include:**

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals



- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to \$5,000.00 payment (when included with Your enrollment in a **StudentResources** (SPC) Ltd., A UnitedHealth Group Company health insurance policy)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit [georgiacare.intlinsure.com](http://georgiacare.intlinsure.com) for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.

To access services please refer to the phone number on the back of your ID Card or access My Account and select the link for Value Added Benefits.

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

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

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

UnitedHealthcare Global is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. Please refer to the UnitedHealthcare Global information in **My Account** at [georgiacare.intlinsure.com](http://georgiacare.intlinsure.com) for additional information, including limitations and exclusions.

## Online Access to Account Information

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**StudentResources** (SPC) Ltd., A UnitedHealth Group Company Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to **My Account** at [georgiacare.intlinsure.com](http://georgiacare.intlinsure.com). Insured students who don't already have an online account may simply select the **"My Account"** link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of **StudentResources** (SPC) Ltd., A UnitedHealth Group Company's environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

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

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## **ID Cards**

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

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## **UHCSR Mobile App**

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The UHCSR Mobile App is available for download from Google Play or Apple's App Store. Features of the Mobile App include easy access to:

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating Healthcare or Mental Health providers, call the office or facility; view a map.
- Find My Claims – view claims received within the past 60 days for both the primary insured and covered dependents; includes Provider, date of service, status, claim amount and amount paid.

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## **Claim Procedure**

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In the event of Injury or Sickness, students should:

1. Report to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number (insured's insurance company ID number) and name of the policy under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

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

**StudentResources (SPC) Ltd., A UnitedHealth Group Company**  
P.O. Box 809025  
Dallas, Texas 75380-9025  
1-888-251-6253  
or visit our website at [georgiacare.intlinsure.com](http://georgiacare.intlinsure.com)

**The Plan is Underwritten by:**

**Student Resources (SPC) Ltd.**

A UNITEDHEALTH GROUP COMPANY

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

This Brochure is based on Policy # 2017-202987-91.

**NOTE: Albany State University has endorsed this policy as being appropriate to offer to international students attending classes at its campus. Albany State University is not the policyholder for this policy and has no relationship to the policyholder. The policyholder of this policy is International Health Consortium SP.**

# **Albany State University**