# UNITEDHEALTHCARE INSURANCE COMPANY

## STUDENT HEALTH INSURANCE PLAN

## CERTIFICATE OF COVERAGE

Designed Especially for the Students of

2023-2024

### This Certificate of Coverage is Part of Policy # 2023-335-2

This Certificate of Coverage ("Certificate") is part of the contract between UnitedHealthcare Insurance Company (hereinafter referred to as the "Company," "We," "Us," and "Our") and the Policyholder.

Please keep this Certificate as an explanation of the benefits available to the Insured Person under the contract between the Company and the Policyholder. This Certificate is not a contract between the Insured Person and the Company. Amendments or endorsements may be delivered with the Certificate or added thereafter. The Master Policy is on file with the Policyholder and contains all of the provisions, limitations, exclusions, and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

**READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS THE INSURED PERSON'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.**

## Table of Contents

## Introduction

Welcome to the UnitedHealthcare Student Resources Student Health Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance Company.

The school (referred to as the "Policyholder") has purchased a Policy from the Company. The Company will provide the benefits described in this Certificate to Insured Persons, as defined in the Definitions section of this Certificate. This Certificate is not a contract between the Insured Person and the Company. Keep this Certificate with other important papers so that it is available for future reference.

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-888-344-5989. The Insured can also write to the Company at:

UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, TX 75380-9025

## Section 1: Who Is Covered

The Master Policy covers students and their eligible Dependents who have met the Policy's eligibility requirements (as shown below) and who:

1. Are properly enrolled in the plan, and
2. Pay the required premium.

All students who are enrolled in a UA graduate program and are receiving Graduate Assistantships (GA) and/or Graduate Fellowships must be enrolled in this insurance plan on a mandatory basis. Graduate students not on GA/Fellowships, but who are receiving tuition and/or fee awards, are eligible to be enrolled in this insurance plan. For GAs and Fellows, the premium is paid by the University on behalf of the student. Plan enrollment is not automatic.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children under 26 years of age. See the Definitions section of this Certificate for the specific requirements needed to meet Domestic Partner eligibility.

The student (Named Insured, as defined in this Certificate) must actively attend classes for at least the first 45 days after the date for which coverage is purchased. 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 and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse or a Domestic Partner who meets the specific requirements set forth in the Definitions section of this Certificate.
   b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

## Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 25, 2023. The Insured Person'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., August 24, 2024. The Insured Person's 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.

There is no pro-rata or reduced premium payment for late enrollees. Refunds of premiums are allowed only upon entry into the armed forces.

The Master Policy is a non-renewable one year term insurance policy. The Master Policy will not be renewed.

## Section 3: Extension of Benefits after Termination

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.

## Section 4: Pre-Admission Notification

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

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

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

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

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

## Section 5: Preferred Provider and Out-of-Network Provider Information

This plan is a preferred provider organization or "PPO" plan. It provides a higher level of coverage when Covered Medical Expenses are received from healthcare providers who are part of the plan's network of Preferred Providers. The plan also provides coverage when Covered Medical Expenses are obtained from healthcare providers who are not Preferred Providers, known as Out-of-Network Providers. However, a lower level of coverage may be provided when care is received from Out-of-Network Providers and the Insured Person may be responsible for paying a greater portion of the cost.

Preferred Providers in the local school area are:

UnitedHealthcare Options PPO

Preferred Provider Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities.

The easiest way to locate Preferred Providers is through the plan's website at www.uhcsr.com/uaf. The website will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at 1-888-344-5989 for assistance in finding a Preferred Provider.

The Company arranges for health care providers to take part in the Preferred Provider network. Preferred Providers are independent practitioners. They are not employees of the Company. It is the Insured's responsibility to choose a provider. Our credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

A provider's status may change. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling Customer Service at 1-888-344-5989 and/or by asking the provider when making an appointment for services. A directory of providers is available on the plan's website at www.uhcsr.com/uaf.

If an Insured receives a Covered Medical Expense from an Out-of-Network Provider and was informed incorrectly by the Company prior to receipt of the Covered Medical Expense that the provider was a Preferred Provider, either through Our provider directory or in Our response to the Insured's request for such information (via telephone, electronic, web-based or internet-based means), the Insured may be eligible for cost-sharing (Copayment, Coinsurance, and applicable Deductible) that would be no greater than if the service had been provided from a Preferred Provider.

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured is eligible to continue to receive care from their current provider for specified conditions and timeframes. Continued care will be provided under the same terms and conditions that would have applied prior to termination of the provider's contract for those specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. An Insured may call the Company at 1-888-344-5989 to find out if they are eligible for continuity of care benefits.

**"Preferred Provider Benefits"** apply to Covered Medical Expenses that are provided by a Preferred Provider.

**"Out-of-Network Provider Benefits"** apply to Covered Medical Expenses that are provided by an Out-of-Network Provider.

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

Allowed Amounts are the amounts the Company will pay for Covered Medical Expenses. Refer to the definition of Allowed Amount in this Certificate for information on how the Company determines Allowed Amounts.

**Preferred Provider Benefits**
The Insured is not responsible for any difference between what the Company pays for Allowed Amounts and the amount the provider bills, except for the Insured Person's cost share obligation as specified in the Schedule of Benefits.

This Certificate includes the following provisions to comply with the applicable requirements of the *Consolidated Appropriations Act (the "Act") (P. L. 116 -260).* These provisions reflect requirements of the Act; however, they do not preempt applicable state law.

**Out-of-Network Provider Benefits**
Except as described below, the Insured Person is responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the provider bills the Insured and the amount the Company pays for Allowed Amounts.

1. For Ancillary Services received at certain Preferred Provider facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
2. For non-Ancillary Services received at certain Preferred Provider facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied in accordance with applicable law, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
3. For Emergency Services provided by an Out-of-Network Provider, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's applicable Copayment, Coinsurance, or Deductible which is based on the rates that would apply if the service was provided by a Preferred Provider which is based on the Recognized Amount as defined in this Certificate.
4. For Air Ambulance services provided by an Out-of-Network Provider, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's applicable Copayment, Coinsurance, or Deductible which is based on the rates that would apply if the service was provided by a Preferred Provider which is based on the Recognized Amount as defined in this Certificate.

For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center (as described in section *1833(i)(1)(A) of the Social Security Act*), and any other facility specified by the Secretary.

**State Continuity of Care; Termination of Provider Contracts**

In the event a contract or agreement between the Company and a health care provider is termination, the Insured may continue to be treated by that health care provider under the following circumstances.

If the Insured is pregnant or is being actively treated by the provider on the date the provider's contract terminations, the Insured may continue to receive Covered Medical Services form the provider for the pregnancy or for the specific condition being treated on the date the contract terminates.

Treatment is required to be covered only while the Policy remains in force and:

1. For the period that is the longest of the following:
   - To the Policy termination date.
   - Up to 90 days after the provider's contract termination date, if the event triggering the right to continue treatment is part of an ongoing course of treatment.
   - Through the completion of postpartum care, if the Insured is pregnant on the date the provider's contract terminates.
2. Until the end of Medically Necessary treatment the Insured has a terminal condition, Sickness, or Injury. For the purpose of this provision, "terminal" means a life expectancy of less than one year.

## Section 6: Medical Expense Benefits

This section describes Covered Medical Expenses for which benefits are available. **Please refer to the attached Schedule of Benefits for benefit details.**

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

Benefits are payable for services delivered via Telemedicine/Telehealth. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section.

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

**Inpatient**

1. **Room and Board Expense.**
   Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

2. **Intensive Care.**
   See Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia.
   - Drugs (excluding take home drugs) or medicines.
   - Therapeutic services.
   - Supplies.

4. **Routine Newborn Care.**
   While Hospital Confined and routine nursery care provided immediately after birth.

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

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

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

Benefits include routine circumcision.

5. **Surgery.**
   Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**
   Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**
   Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**
   Registered Nurse's services which are all of the following:
   - Private duty nursing care only.
   - Received when confined as an Inpatient.
   - Ordered by a licensed Physician.
   - A Medical Necessity.

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

9. **Physician's Visits.**
   Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**
    Benefits are limited to routine tests such as:
    - Complete blood count.
    - Urinalysis.
    - Chest X-rays.

    If otherwise payable under the Policy, major diagnostic procedures such as those listed below will be paid under the Hospital Miscellaneous benefit:
    - CT scans.
    - NMR's.
    - Blood chemistries.

**<u>Outpatient</u>**

11. **Surgery.**
    Physician's fees for outpatient surgery.

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

13. **Assistant Surgeon Fees.**
    Assistant Surgeon Fees in connection with outpatient surgery.

14. **Anesthetist Services.**
    Professional services administered in connection with outpatient surgery.

15. **Physician's Visits.**
    Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery or Physiotherapy.

Physician's Visits for preventive care are provided as specified under Preventive Care Services.

16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. Other than as provided for Habilitative Services, 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.

Physiotherapy provided in the Insured Person's home by a home health agency is provided as specified under Home Health Care. Physiotherapy provided in the Insured's home other than by a home health agency is provided as specified under this benefit.

17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
- Facility charge for use of the emergency room and supplies.

All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.

18. **Diagnostic X-ray Services.**
Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.

19. **Radiation Therapy.**
See Schedule of Benefits.

20. **Laboratory Procedures.**
Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

21. **Tests and Procedures.**
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
- Physician's Visits.
- Physiotherapy.
- X-rays.
- Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.

Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. **Injections.**
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy.**
See Schedule of Benefits.

24. **Prescription Drugs.**
See Schedule of Benefits.

## Other

25. **Ambulance Services.**
See Schedule of Benefits.

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

For the purposes of this benefit, the following are considered durable medical equipment.
- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part.

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

27. **Consultant Physician Fees.**
Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:
- Injury to Sound, Natural Teeth.
- Removal of impacted wisdom teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

Pediatric dental benefits are provided in the Pediatric Dental Services provision.

Benefits will be provided for Medically Necessary general anesthesia and related facility services if:
- The Insured Person is under age 7 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office.
- The Insured has a medical condition in addition to the dental condition needing treatment that the Physician finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center.

29. **Mental Illness Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

30. **Substance Use Disorder Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

31. **Maternity.**
Same as any other Sickness.

Benefits will be paid for an inpatient stay of at least:
- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

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

32. **Complications of Pregnancy.**
Same as any other Sickness.

33. **Preventive Care Services.**
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

34. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy.

Benefits include:
- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of mastectomy, including lymphedemas.

35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Treatment of Diabetes and Benefits for Diabetes Outpatient Self-Management.

36. **Home Health Care.**
Services received from a licensed home health agency that are:
- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person’s home.
- Pursuant to a home health plan.

Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.

37. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.

Hospice care includes:
- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.

38. **Inpatient Rehabilitation Facility.**
Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

39. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

40. **Urgent Care Center.**
Benefits are limited to:
- Facility or clinic fee billed by the Urgent Care Center.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

41. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- Facility or clinic fee billed by the Hospital.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

42. **Approved Clinical Trials.**
Routine Patient Care Costs incurred while taking part in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the Policy. Routine patient care costs do not include:
- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

See also Benefits for Routine Care Costs for Cancer Clinical Trials.

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

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

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

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

44. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the attached Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits endorsements.

45. **Acupuncture Services.**
See Schedule of Benefits.

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

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

47. **Medical Supplies.**
Medical supplies must meet all of the following criteria:

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

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

48. **Nutrition Programs.**
Benefits for nutrition programs are limited to nutritional counseling services provided by a licensed health professional to develop a dietary treatment plan to treat and/or manage conditions, included but not limited to such as diabetes, heart failure, kidney failure, high cholesterol, anorexia or bulimia when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Non-disease specific, nutritional education such as general good eating habits, calorie control or dietary preferences (e.g. vegetarian, macro-biotic) is excluded from coverage. The cost of food is not covered. See also Benefits for Preventive Care Services.

49. **Ostomy Supplies.**
Benefits for ostomy supplies are limited to the following supplies:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

## Section 7: Mandated Benefits

### BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Sickness for screening mammography to identify breast cancer according to the following guidelines:

1. A baseline mammogram for women age 35 to age 39.
2. One mammogram every two years for women age 40 to 49, or more frequently if recommended by a physician.
3. An annual mammogram for women age 50 and over.
4. A mammogram at any age for a covered Insured with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by a Physician.

"Low-dose Mammography Screening" and "Mammogram" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure to deliver less than one rad mid-breast, with two views for each breast.

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

### BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for an annual Prostate Cancer Screening Test. "Prostate cancer screening tests" includes a prostate antigen blood test or another test that is equivalent or better in cancer detection when performed by or recommended by a Physician.

Benefits are provided for men who are:

1. At least 35 years of age but less than 40 years of age and the Insured Person is in a high risk group. "High risk" means a person who is African-American or who has a family history of prostate cancer.
2. 40 years of age or more.

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

### BENEFITS FOR CERVICAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for an annual pap smear test for an Insured Person who is 18 or more years of age.

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

### BENEFITS FOR PHENYLKETONURIA

Benefits will be paid the same as any other Sickness for formulas necessary for the treatment of Phenylketonuria, when under the supervision of a Physician and Medically Necessary for the therapeutic treatment of Phenylketonuria.

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

### BENEFITS FOR TREATMENT OF DIABETES

Benefits will be paid the same as any other prescription or pharmacy services for the treatment of Diabetes. Benefits shall include medication, equipment, and supplies when prescribed by a Physician.

"Diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes.

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

## BENEFITS FOR DIABETES OUTPATIENT SELF-MANAGEMENT

Benefits will be paid the same as any other Sickness for outpatient self-management training or education and medical nutrition therapy for the treatment of diabetes if diabetes treatment is prescribed by a Physician. Diabetes outpatient self-management training or education and medical nutrition therapy must be provided by a Physician with training in the treatment of diabetes.

"Diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes.

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

## BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for colorectal cancer screening examinations and laboratory tests for an asymptomatic Insured Person in accordance with and at the frequency identified in the current American Cancer Society guidelines for colorectal cancer screenings.

Benefits apply to an Insured Person who is:

1. At least 50 years of age.
2. Less than 50 years and at high risk for colorectal cancer. For Insured Persons considered at high risk, screenings shall be provided at a frequency determined necessary by a Physician.

An Insured Person is considered at high risk for colorectal cancer because of any of the following:

1. Family history.
2. Prior experience of cancer or precursor neoplastic polyps.
3. A history of a chronic digestive disease condition, including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis.
4. The presence of any appropriate recognized gene markers for colorectal cancer.
5. Other predisposing factors.

The current American Cancer Society guidelines recommend one of the following screening tests for individuals who are at average risk beginning at age 50.

**Tests that find polyps and cancer:**
1. Flexible sigmoidoscopy every 5 years; or
2. Colonoscopy every 10 years; or
3. Double-contrast barium enema every 5 years; or
4. CT colonography (virtual colonoscopy) every 5 years.

**Tests that primarily find cancer:**
1. Yearly fecal occult blood test (FOBT); or
2. Yearly fecal immunochemical test (FIT).

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

## BENEFITS FOR ROUTINE CARE COSTS FOR CANCER CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for Insured's routine care costs associated with an approved cancer clinical trial. The Insured's treating Physician must determine both:

1. There is no superior non-investigative treatment alternative.
2. Available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any non-investigational alternative.

Benefits for routine care costs include all of the following:

1. Prevention, diagnosis, treatment, and palliative care of cancer.
2. Medical care for an Approved Clinical Trial related to cancer that would otherwise be covered under the plan if the medical care was not in connection with an Approved Clinical Trial related to cancer.

3. Items or services necessary to provide an investigational item or service.
4. The diagnosis or treatment of complications.
5. A drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device.
6. Services necessary to administer a drug or device under evaluation in the clinical trial.
7. Transportation for the Insured that is primarily for and essential to medical care.

Benefits for routine care costs do not include:

1. A drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration.
2. Housing, companion expenses, or other nonclinical expenses associated with the clinical trial.
3. An item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the Insured.
4. An item or service excluded from coverage under the plan.
5. An item or service paid for or customarily paid for through grants or other funding.

"Approved Clinical Trials" means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care of a subject, if the study is approved by an institutional review board and one of the following:

1. The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers.
2. The United States Department of Health and Human Services, United Stated Food and Drug Administration.
3. The United States Department of Defense.
4. The United States Department of Veterans Affairs.
5. A nongovernmental research entity abiding by current Nation Institutes of Health guidelines.

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

**BENEFITS FOR AUTISM SPECTRUM DISORDERS**

Benefits will be paid the same as any other Mental Illness for the costs of the diagnosis and treatment of Autism Spectrum Disorders for Insured Persons. No Policy visit limits will apply to the number of visits to an Autism Service Provider.

Benefits include treatment prescribed by a licensed Physician, psychologist, or advanced practice registered nurse, provided by or supervised by an Autism Service Provider, and as identified in a treatment plan developed following a comprehensive evaluation, including:

1. Medically Necessary pharmacy care.
2. Psychiatric care.
3. Psychological care.
4. Habilitative care or Rehabilitative Care, including applied behavioral analysis.
5. Therapeutic care.

"Autism Spectrum Disorders" means Pervasive Developmental Disorders, or a group of conditions having substantially the same characteristics as Pervasive Developmental Disorders, as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-IV-TR, as amended or reissued from time to time.

"Autism Service Provider" means an individual who is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized certifying organization and who provides direct services to an Insured Person with an Autism Spectrum Disorder.

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

**BENEFITS FOR NEWBORN INFANT HEARING SCREENING**

Benefits will be paid the same as any other Sickness for a Newborn Infant hearing screening to be performed within 30 days after the Newborn Infant's birth. If the initial screening determines that the child may have a hearing impairment, benefits shall also include a confirmatory hearing diagnostic evaluation.

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

**BENEFITS FOR WELL-BABY EXAMS**

Benefits will be paid the same as any other Sickness for routine Well-baby Exams performed by a qualified Health Care Professional for a Dependent child.

"Well-Baby Exams" means:

1. A periodic physical examination by a qualified Health Care Professional of a baby during the first 24 months of life in which information is collected on matters including normal development, growth rate, hearing, vision, language skills, motor development, diet, general care, preventative health care, immunizations, and infectious diseases.
2. Consultation between the Health Care Professional and a parent.

"Health Care Professional" means a health aide, physician, nurse, and physician assistant, but does not include a practitioner of religious healing.

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

**BENEFITS FOR ANTI-CANCER MEDICATIONS**

Benefits for patient-administered anti-cancer medications, including those orally administered or self-injected, will be provided on a basis no less favorable than anti-cancer medication injected or intravenously administered by a health care provider.

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

## Section 8: Excess Provision

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 on the Insured for failing 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.

## Section 9: Accidental Death and Dismemberment Benefits

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

**For Loss Of**

| | |
|---|---|
| Life | $7,500.00 |
| Two or More Members | $7,500.00 |
| One Member | $1,000.00 |

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.

## Section 10: Definitions

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

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

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

**AIR AMBULANCE** means medical transport by rotary wing air ambulance or fixed wing air ambulance as defined in *42 CFR 414.605*.

**ALLOWED AMOUNT** means the maximum amount the Company is obligated to pay for Covered Medical Expenses. Allowed amounts are determined by the Company or determined as required by law, as described below.

Allowed amounts are based on the following:

When Covered Medical Expenses are received from a Preferred Provider, allowed amounts are the Company's contracted fee(s) with that provider.

When Covered Medical Expenses are received from an Out-of-Network Provider as described below, allowed amounts are determined as follows:

1. **For non-Medical Emergency Covered Medical Expenses received at certain Preferred Provider facilities from Out-of-Network Provider Physicians** when such services are either: a) Ancillary Services; or b) non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary, the allowed amount is based on one of the following in the order listed below as applicable:
   - No less than the 80th percentile of available data resources of competitive fees in that geographical area, or equivalent.
   - The amount subsequently agreed to by the Out-of-Network Provider and the Company.

   For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center (as described in section *1833(i)(1)(A) of the Social Security Act*), and any other facility specified by the Secretary.

2. **For Emergency Services provided by an Out-of-Network Provider**, the allowed amount is based on one of the following in the order listed below as applicable:
   - No less than the 80th percentile of available data resources of competitive fees in that geographical area, or equivalent.
   - The amount subsequently agreed to by the Out-of-Network Provider and the Company.

3. **For Air Ambulance transportation provided by an Out-of-Network Provider**, the allowed amount is based on one of the following in the order listed below as applicable:
   - No less than the 80th percentile of available data resources of competitive fees in that geographical area, or equivalent.
   - The amount subsequently agreed to by the Out-of-Network Provider and the Company.

When Covered Medical Expenses are received from an Out-of-Network Provider or facility, except as described above, the allowed amounts will be based on the lesser of the following:

1. No less than the 80th percentile of available data resources of competitive fees in that geographic area, or equivalent.
2. Fees that are negotiated with the provider/facility.
3. 100% of the billed charge.

**ANCILLARY SERVICES** means items and services provided by Out-of-Network Provider Physicians at a Preferred Provider facility that are any of the following:

1. Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
2. Provided by assistant surgeons, hospitalists, and intensivists.
3. Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary.
4. Provided by such other specialist practitioners as determined by the Secretary.
5. Provided by an Out-of-Network Provider Physician when no other Preferred Provider Physician is available.

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

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

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

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

**COVERED MEDICAL EXPENSES** means health care services and supplies which are all of the following:

1. Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness or Injury.
2. Medically Necessary.
3. Specified as a covered medical expense in this Certificate under the Medical Expense Benefits or in the Schedule of Benefits.
4. Not in excess of the Allowed Amount or the Recognized Amount when applicable.
5. Not in excess of the maximum benefit payable per service as specified in the Schedule of Benefits.
6. Not excluded in this Certificate under the Exclusions and Limitations.
7. In excess of the amount stated as a Deductible, if any.

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

**CUSTODIAL CARE** means services that are any of the following:

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

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

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

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

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

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

If proof of incapacity and dependency has not been furnished and 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 handicapped as defined by subsections (1) and (2).

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

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

**EMERGENCY SERVICES** means, with respect to a Medical Emergency, both:

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition.
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)*).

Emergency services include items and services otherwise covered under the Policy when provided by an Out-of-Network Provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient stay or outpatient stay that is connected to the original emergency medical condition, unless each of the following conditions are met:

1. The attending Physician or treating provider for the Medical Emergency determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available Preferred Provider or Preferred Provider facility located within a reasonable distance taking into consideration the patient's medical condition.
2. The provider furnishing the additional items and services satisfied the notice and consent criteria in accordance with applicable law.
3. The patient is in such a condition to receive information as stated in 2 above and to provide informed consent in accordance with applicable law.
4. The provider or facility satisfied any additional requirements or prohibitions as may be imposed by state law.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

**HABILITATIVE SERVICES** means medical services or devices provided when Medically Necessary for development of bodily or cognitive functions to perform activities of daily living that never developed or did not develop appropriately based on the chronological age of the Insured Person. Habilitative services include occupational therapy, physical therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope of his or her license. Therapy to retain skills necessary for activities of daily living and prevent regression to a previous level of function is a habilitative service, if Medically necessary and appropriate. Habilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.

Habilitative services do not include respite care, day habilitation services designed to provide training, structured activities and specialized assistance for adults, chore services to assist with basic needs, educational, vocational, recreational or custodial services.

**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 on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

**INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT** means a health care facility that: 1) is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and 2) provides Emergency Services.

**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 the 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 the Policy's Effective Date will be considered a Sickness under the Policy.

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

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

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

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

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

**MEDICAL EMERGENCY** means a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in any of the following:

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

Expenses incurred for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

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

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

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

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

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

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

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

**NEWBORN INFANT** means any child born of an Insured while that person is insured under the 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 the Company; 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-NETWORK PROVIDER** means a provider who does not have a contract with the Company to provide services to Insured Persons.

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

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

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

**PHYSIOTHERAPY** means short-term outpatient rehabilitation therapies (including Habilitative Services) administered by a Physician.

**POLICY OR MASTER POLICY** means the entire agreement issued to the Policyholder that includes all of the following:

1. The Policy.
2. The Policyholder Application.
3. The Certificate of Coverage.
4. The Schedule of Benefits.
5. Endorsements.
6. Amendments.

**POLICY YEAR** means the period of time beginning on the Policy Effective Date and ending on the Policy Termination Date.

**POLICYHOLDER** means the institution of higher education to whom the Master Policy is issued.

**PREFERRED PROVIDER** means a provider that has a participation agreement in effect (either directly or indirectly) with the Company or Our affiliates to participate in Our preferred provider network. Our affiliates are those entities affiliated with the Company through common ownership or control with Us or with Our ultimate corporate parent, including direct and indirect subsidiaries.

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

**RECOGNIZED AMOUNT** means the amount which any Copayment, Coinsurance, and applicable Deductible is based on for the below Covered Medical Expenses when provided by Out-of-Network Providers:

1. Out-of-Network Emergency Services.
2. Non-Emergency Services received at certain Preferred Provider facilities by Out-of-Network Provider Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on the lesser of:

1. The reimbursement rate as determined by Alaska Administrative Code which requires an $80^{th}$ percentile reimbursement rate.
2. The amount billed by the provider or the facility.

The recognized amount for Air Ambulance services provided by an Out-of-Network Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

**Note:** Covered Medical Expenses that use the recognized amount to determine the Insured's cost sharing may be higher or lower than if cost sharing for these Covered Medical Expenses were determined based on an Allowed Amount.

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

**SECRETARY** means the Secretary of Health and Human Services as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

**SICKNESS** means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under the 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 the Policy's Effective Date will be considered a sickness under the Policy.

**SKILLED NURSING FACILITY** means a Hospital or nursing facility that is licensed and operated as required by law.

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

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

**TELEHEALTH/TELEMEDICINE** means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the Insured or from each other or between a provider and an Insured who are physically separated from each other.

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

## Section 11: Exclusions and Limitations

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

1. Acne.
2. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
3. Learning disabilities.
4. Circumcision, except as specifically provided in the Policy benefits for Routine Newborn Care.
5. Cosmetic procedures, except reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
6. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As specifically provided in the Schedule of Benefits.
   - As described under Dental Treatment in the Policy.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
7. Elective Surgery or Elective Treatment.
8. Foot care for the following:
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
9. Hearing examinations, except as specifically provided in the Benefits for Newborn Infant Hearing Screening. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

   This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of an infection or Injury.
10. Hirsutism. Alopecia.
11. 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.
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
13. Injury sustained while:
    - Participating in any intercollegiate or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
14. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
15. 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.
    - 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.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
16. Reproductive services for the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.

- Cryopreservation of reproductive materials. Storage of reproductive materials.
- Fertility tests.
- Infertility treatment (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.
- Reversal of sterilization procedures.

17. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy for Approved Clinical Trials and Benefits for Routine Care Costs for Cancer Clinical Trials.
18. Routine eye examinations, except as specifically provided in the Policy for Well-Baby Exams. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To eyeglasses or contact lenses for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of the cornea, tear film insufficiency, aphakia, Sjogren's syndrome, congenital cataract, corneal abrasion and keratoconus.
19. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy benefit for Routine Newborn Care.
20. Preventive services including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.

    This exclusion does not apply to benefits specifically provided in the Policy for Preventive Care Services.
21. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
22. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Temporomandibular joint dysfunction. 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 sinusitis.
23. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
24. Sleep disorders.
25. Speech therapy, except as specifically provided in the Policy for Physiotherapy.
26. Supplies, except as specifically provided in the Policy.
27. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
28. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
29. 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).
30. Weight management. Weight reduction. Nutrition programs, except as specifically provided in the Policy for Nutrition Programs. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

## Section 12: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2. Insureds can submit claims online in their My Account at www.uhcsr.com/MyAccount or submit claims by mail. If submitting by mail, send 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 university 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.

If submitting a claim by mail, send the above information to the Company at:

UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, TX 75380-9025

## Section 13: General Provisions

**GRACE PERIOD**: A grace period of 14 days will be provided for the payment of each premium payment due after the first premium. The Insured Person's premium must be received during the grace period to avoid a lapse in coverage, and the Insured Person must meet the eligibility requirements each time a premium payment is made

**NOTICE OF CLAIM:** Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 or to an authorized agent of the insurer with information sufficient to identify the Named Insured shall be deemed notice to the Company.

**CLAIM FORMS:** Claim forms are not required. The Insured should submit written proof covering the occurrence within the time fixed in the Proof of Loss General Provision. Proof includes the medical and/or hospital bills, patient's name and Insured student's name, address, Insured's insurance company ID number (SR ID) and name of the college or university under which the student is insured.

**PROOF OF LOSS:** Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIM:** Indemnities payable under the Policy for any loss will be paid within 30 calendar days upon receipt of a clean claim. If the claim is denied or pended for further information, the Company will notify the health care provider or the Insured within 30 calendar days from receipt of the claim the reason for denying or pending the claim and what, if any, additional information is required to process the claim. If the Company provides such notice, the Company shall pay the claim not later than 15 calendar days after the receipt of the information or within 30 days after receipt of the claim. The Company's failure to comply with the time limits in this section will result in an accrual of interest at a rate of 15%, and will continue to accrue until the date the claim is paid.

**PAYMENT OF CLAIMS:** All indemnities provided by the Policy will be payable to the Named Insured, unless the Named Insured requests in writing, not later than the time of filing proofs of such loss, that payment be made directly to the Hospital or person rendering such service.

Indemnities provided under the Policy for any of the Out-of-Network Provider services listed in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* will be paid directly to the Provider.

**PHYSICAL EXAMINATION:** As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

**LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proofs of loss are required to be furnished.

**SUBROGATION:** The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

**RIGHT OF RECOVERY:** Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear. The Company will provide written notice to a health care provider, health care facility, or Insured at least 30 calendar days before the Company seeks recovery of an overpayment. The notice will include adequate information for the health care provider, health care facility, or Insured to identify the specific claim and specific reason for the recovery. A health care provider, health care facility, or Insured will be given the opportunity to challenge the recovery of an overpayment, including sharing of claims information. The Company will not initiate recovery of an overpayment more than 365 days after the date the original payment was made, unless the Company has clear and documented reason to believe the health care provider, health care facility, Insured, or its agents have committed fraud or other intentional misconduct.

**MORE THAN ONE POLICY:** Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

## Section 14: Notice of Appeal Rights

**RIGHT TO INTERNAL APPEAL**
**Standard Internal Appeal**

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal after receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 888-344-5989 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare Student Resources, PO Box 809025, Dallas, TX 75380-9025.

**Internal Appeal Process**
After receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination.

Upon receipt of the request for an Internal Review, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination and is one who typically treats the illness which is the subject of the Adverse Determination.

Within three working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:

1. Any new or additional evidence considered by the Company in connection with the grievance; and
2. Any new or additional rationale upon which the decision was based.

The Insured Person or Authorized Representative shall have 10 calendar days to respond to any new or additional evidence or rationale.

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative as follows:

1. For a Prospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.

Time periods shall be calculated based on the date the Company receives the request for the Internal Review, without regard to whether all of the information necessary to make the determination accompanies the request.

The written notice of Final Adverse Determination for the Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
   a. The date of service;
   b. The name health care provider; and
   c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
   d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
   e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
   f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and

**Expedited Internal Review**

For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Review (EIR).

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact Claims Appeals at 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare Student Resources, PO Box 809025, Dallas, TX 75380-9025.

**Expedited Internal Review Process**

The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:

1. Involving Urgent Care Requests; and
2. Related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Authorized

Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue without liability to the Insured Person until the Insured Person has been notified of the final determination.

At the same time an Insured Person or an Authorized Representative files an EIR request, the Insured Person or the Authorized Representative may file:

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

The notice of Final Adverse Determination may be provided orally, in writing, or electronically.

**RIGHT TO EXTERNAL INDEPENDENT REVIEW**

After exhausting the Company's Internal Appeal process, an Insured Person or Authorized Representative may submit a request for an External Independent Review when the service or treatment in question:

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

A request for an External Independent Review shall not be made until the Insured Person or Authorized Representative has exhausted the Internal Appeals process. The Internal Appeal Process shall be considered exhausted if:

1. The Company has issued a Final Adverse Determination as detailed herein;
2. The Insured Person or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the Company within 30 days and the Insured Person or Authorized Representative has not requested or agreed to a delay;
3. The Company fails to strictly adhere to the Internal Appeal process detailed herein; or
4. The Company agrees to waive the exhaustion requirement.

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 180 days to request an External Independent Review. The Director will extend the 180 day time period if the Insured Person or Authorized Representative files a request for an extension. The request for the extension needs to provide one or more justifications for the extension that a prudent person would consider to be a fair and reasonable basis for allowing the extension. The request to file the extension does not need to be within the 180 day filing period. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Director. Upon request of an External Review, the Director shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

The Insured Person or Authorized Representative may also submit a request for an External Independent Review when the Insured receives an Adverse Determination related to an Out-of-Network Provider claim subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

**Where to Send External Review Requests**

All types of External Review requests shall be submitted to the Division of Insurance at the following address:

Alaska Division of Insurance
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501-3567
Phone: (907) 269-7900
Fax: (907) 269-7910
Email: insurance@alaska.gov
Website: https//www.commerce.alaska.gov/web/ins/

**Standard External Review (SER) Process**

A Standard External Review request must be submitted in writing within 180 days of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

1. Within five business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. Within one business day after completion of the preliminary review, the Company shall notify the Director, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
3. After determining that a request is eligible for SER, the Director shall, within one business day:
   a. Assign an Independent Review Organization (IRO) from the Director's approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within five business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4. a. The Company shall, within five business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within one business day, advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
   b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
   c. If the Company reverses it decision, the Company shall provide written notification within one business day to the Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Director, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

**Expedited External Review (EER) Process**
An Expedited External Review request may be submitted either orally or in writing when:

8. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Director at the time the Insured Person receives:
   a. An Adverse Determination if:
      - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      - The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
   b. A Final Adverse Determination, if:

- The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
- The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received Emergency Services, but has not been discharged from a facility.

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.

1. Upon receipt of an EER request, the Director shall immediately send a copy of the request to the Company.
2. Upon receipt of a request for an EER, the Company shall immediately review the request to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
3. Immediately after completion of the review, the Company shall notify the Director, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
4. When a request is complete and eligible for an EER, the Director shall immediately assign an Independent Review Organization (IRO) from the Director's approved list and notify the Company of the name of the assigned IRO.
   a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
   b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
5. a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
   b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
6. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
   a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
   b. Notify the Director, the Company, the Insured Person, and, if applicable, the Authorized Representative.
7. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

**BINDING EXTERNAL REVIEW**

An External Review decision is binding on the Company except to the extent the Company has other remedies available under state law. An External Review decision is binding on the Insured Person unless the Insured Person who is aggrieved by a Final Adverse Determination appeals the decision to the superior court. An appeal of the Final Adverse Determination must be filed within six months after the date of the Final Adverse Determination.

**APPEAL RIGHTS DEFINITIONS**

For the purpose of this Notice of Appeal Rights, the following terms are defined as shown below:

**Adverse Determination** means:

1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy as an Insured Person;
3. Any prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy; or
4. A rescission of coverage.

**Authorized Representative** means:

1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

**Evidenced–based Standard** means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

**Final Adverse Determination** means an Adverse Determination involving a Covered Medical Expense that has been upheld by the Company, at the completion of the Company's internal appeal process or an Adverse Determination for which the internal appeals process has been deemed exhausted in accordance with this notice.

**Prospective Review** means Utilization Review performed: 1) prior to an admission or the provision of a health care service or course of treatment; and 2) in accordance with the Company's requirement that the service be approved, in whole or in part, prior to its provision.

**Retrospective Review** means any review of a request for a Covered Medical Expense that is not a Prospective Review request. Retrospective review does not include the review of a claim that is limited to the veracity of documentation or accuracy of coding.

**Urgent Care Request** means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or
2. In the opinion of a physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

**Utilization Review** means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

**Questions Regarding Appeal Rights**

Contact Customer Service at 1-888-344-5989 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

Division of Insurance
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501-3567
Phone: (907) 269-7900
Fax: (907) 269-7910
Email: insurance@alaska.gov
Website: https://www.commerce.alaska.gov/web/ins/

## Section 15: Online Access to Account Information

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

As part of UnitedHealthcare Student Resources' 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 a message center - a self-service tool that provides a quick and easy way to view any email notifications the Company may have sent. 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 Profile and making the change there.

## Section 16: ID Cards

Digital ID cards will be made available to each Insured Person. The Company will send an email notification when the digital ID card is available to be downloaded from My Account**.** An Insured Person may also use My Account to request delivery of a permanent ID card through the mail.

## Section 17: UHCSR Mobile App

The UHCSR Mobile App is available for download from Google Play or the 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, find contact information for the provider's office or facility, and locate the provider's office or facility on a map.
- Find My Claims – view claims received within the past 120 days for both the primary Insured and covered Dependents; includes provider, date of service, status, claim amount and amount paid.

## Section 18: Important Company Contact Information

The Policy is Underwritten by:
**UNITEDHEALTHCARE INSURANCE COMPANY**

Administrative Office:
UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-888-344-5989
Website: www.uhcsr.com/uaf

Sales/Marketing Services:
UnitedHealthcare Student Resources
11399 16th Courth North, Suite 110
St. Petersburg, FL 33716
Email: info@uhcsr.com

**Customer Service:**
**888-344-5989**
**(Customer Services Representatives are available Monday - Friday, 7:00 a.m. – 7:00 p.m. (Central Time))**

## Schedule of Benefits

**University of Alaska Fairbanks**
**2023-335-2**
**METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 87.040%**
**Injury and Sickness Benefits**

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

| | |
|---|---|
| **Deductible Preferred Provider** | $400 (Per Insured Person, Per Policy Year) |
| **Deductible Out-of-Network Provider** | $800 (Per Insured Person, Per Policy Year) |
| **Coinsurance Preferred Provider** | 80% except as noted below |
| **Coinsurance Out-of-Network Provider** | 70% except as noted below |
| **Out-of-Pocket Maximum Preferred Provider** | $3,000 (Per Insured Person, Per Policy Year) |
| **Out-of-Pocket Maximum Preferred Provider** | $6,000 (For all Insureds in a Family, Per Policy Year) |
| **Out-of-Pocket Maximum Out-of-Network Provider** | $13,700 (Per Insured Person, Per Policy Year) |
| **Out-of-Pocket Maximum Out-of-Network Provider** | $27,400 (For all Insureds in a Family, Per Policy Year) |

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

The **Preferred Provider** for this plan is UnitedHealthcare Options PPO.

**Preferred Provider Benefits** apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. “Network area” means, within the state of Alaska, the 50 mile radius around the Insureds residence.

**Out-of-Network Provider Benefits** apply to Covered Medical Expenses that are provided by an Out-of-Network Provider. Refer to the *Preferred Provider and Out-of-Network Provider Information* section of the Certificate for information on reimbursement for Emergency Services provided by an Out-of-Network Provider, Covered Medical Expenses provided at certain Preferred Provider facilities by an Out-of-Network Physician, and Air Ambulance transport provided by an Out-of-Network Provider. All other Covered Medical Expenses provided by an Out-of-Network Provider at a Preferred Provider facility will be paid at the Preferred Provider Benefit level.

**Out-of-Pocket Maximum:** After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network Provider Benefits. Any applicable Coinsurance, Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays.

**Student Health Center Benefits:** The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health and Counseling Center. Policy Exclusions and Limitations do not apply.

Graduate students paid a stipend, assigned to remote Alaskan locations by the University, without access to the Student Health and Counseling Center will have the policy Deductible waived for Covered Medical Expenses under the plan.

No benefits are available under this plan for any expenses associated with a period when there is no coverage. For example, prescriptions (such as birth control) will only be covered during the period when coverage is in effect.

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

| Inpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| **Room and Board Expense** | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |
| **Intensive Care** | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |
| **Hospital Miscellaneous Expenses** | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |
| **Routine Newborn Care** | Paid as any other Sickness | Paid as any other Sickness |
| **Surgery**<br>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. | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |
| **Assistant Surgeon Fees**<br>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. | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |
| **Anesthetist Services** | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |
| **Registered Nurse's Services** | No Benefits | No Benefits |
| **Physician's Visits** | $25 Copay per visit<br>100% of Allowed Amount not subject to Deductible | 70% of Allowed Amount after Deductible |
| **Pre-admission Testing**<br>Payable within 7 working days prior to admission. | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |

| Outpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| **Surgery**<br>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. | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |
| **Day Surgery Miscellaneous** | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |
| **Assistant Surgeon Fees**<br>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. | 80% of Allowed Amount after Deductible | 70% of Allowed Amount after Deductible |

| Outpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| **Anesthetist Services** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Physician's Visits** | $35 Copay per visit<br>100% of Allowed Amount<br>not subject to Deductible | $35 Copay per visit<br>70% of Allowed Amount<br>after Deductible |
| **Physiotherapy**<br>Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Medical Emergency Expenses**<br>The Copay will be waived if admitted to the Hospital. | $200 Copay per visit<br>80% of Allowed Amount<br>after Deductible | $200 Copay per visit<br>70% of Allowed Amount<br>after Deductible |
| **Diagnostic X-ray Services** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Radiation Therapy** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Laboratory Procedures** | $35 Copay per visit<br>100% of Allowed Amount<br>not subject to Deductible | $35 Copay per visit<br>70% of Allowed Amount<br>after Deductible |
| **Tests & Procedures** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Injections** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Chemotherapy** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Prescription Drugs**<br><br>*See UHCP Prescription Drug Benefit Endorsement for additional information.<br><br>Prescription Drugs dispensed at the Student Health Center are payable at 100% and are not subject to the Copays. Self-Injectables are not covered. | *UnitedHealthcare Pharmacy (UHCP),<br>Retail Network Pharmacy<br>$25 Copay per prescription Tier 1<br>$45 Copay per prescription Tier 2<br>$75 Copay per prescription Tier 3<br>up to a 31-day supply per prescription<br>not subject to Deductible<br><br>When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge).<br><br>UHCP Mail Order Network Pharmacy or Preferred 90-Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90 day supply. | $25 Copay per prescription generic drug<br>$75 Copay per prescription brand-name drug<br>up to a 31-day supply per prescription<br>not subject to Deductible |

| Other | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| **Ambulance Services** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Durable Medical Equipment** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Consultant Physician Fees** | $25 Copay per visit<br>100% of Allowed Amount<br>not subject to Deductible | 70% of Allowed Amount<br>after Deductible |
| **Dental Treatment**<br>Benefits paid on Injury to Sound, Natural Teeth only. | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |

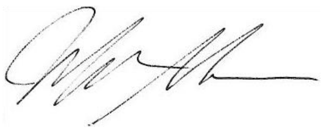
| Other | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| **Dental Treatment**<br>Benefits paid for removal of abscessed or impacted wisdom teeth only. | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Mental Illness Treatment** | **Inpatient:**<br>80% of Allowed Amount<br>after Deductible<br><br>**Outpatient office visits:**<br>$25 Copay per visit<br>100% Allowed Amount<br>not subject to Deductible<br><br>**All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:**<br>80% of Allowed Amount<br>after Deductible | **Inpatient:**<br>70% of Allowed Amount<br>after Deductible<br><br>**Outpatient office visits:**<br>70% of Allowed Amount<br>after Deductible<br><br>**All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:**<br>70% of Allowed Amount<br>after Deductible |
| **Substance Use Disorder Treatment** | **Inpatient:**<br>80% of Allowed Amount<br>after Deductible<br><br>**Outpatient office visits:**<br>$25 Copay per visit<br>100% of Allowed Amount<br>not subject to Deductible<br><br>**All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:**<br>80% of Allowed Amount<br>after Deductible | **Inpatient:**<br>70% of Allowed Amount<br>after Deductible<br><br>**Outpatient office visits:**<br>70% of Allowed Amount<br>after Deductible<br><br>**All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:**<br>70% of Allowed Amount<br>after Deductible |
| **Maternity** | Paid as any other Sickness | Paid as any other Sickness |
| **Complications of Pregnancy** | Paid as any other Sickness | Paid as any other Sickness |
| **Elective Abortion**<br>$500 maximum per Policy Year | Paid as any other Sickness | Paid as any other Sickness |
| **Preventive Care Services**<br>No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider.<br><br>Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups. | 100% of Allowed Amount | 70% of Allowed Amount<br>after Deductible |
| **Reconstructive Breast Surgery Following Mastectomy** | Paid as any other Sickness | Paid as any other Sickness |
| **Diabetes Services**<br>See Benefits for Treatment of Diabetes and Benefits for Diabetes Outpatient Self-Management | Paid as any other Sickness | Paid as any other Sickness |
| **Home Health Care** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Hospice Care** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Inpatient Rehabilitation Facility** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |

| Other | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| **Skilled Nursing Facility** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Urgent Care Center** | $50 Copay per visit<br>100% of Allowed Amount<br>not subject to Deductible | 70% of Allowed Amount<br>after Deductible |
| **Hospital Outpatient Facility or Clinic** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Approved Clinical Trials**<br>See also Benefits for Routine Care Costs for Cancer Clinical Trials | Paid as any other Sickness | Paid as any other Sickness |
| **Transplantation Services** | Paid as any other Sickness | Paid as any other Sickness |
| **Pediatric Dental and Vision Services** | See endorsements attached for Pediatric Dental and Vision Services benefits | See endorsements attached for Pediatric Dental and Vision Services benefits |
| **Acupuncture Services** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Hearing Aids** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Medical Supplies**<br>Benefits are limited to a 31-day supply per purchase. | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |
| **Nutrition Programs** | Paid as any other Sickness | Paid as any other Sickness |
| **Ostomy Supplies** | 80% of Allowed Amount<br>after Deductible | 70% of Allowed Amount<br>after Deductible |

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

**This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all of the terms and conditions of the Policy not inconsistent therewith.**



**President**

**It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:**

## Pediatric Dental Services Benefits

Benefits are provided under this endorsement for Covered Dental Services, as described below, for Insured Persons under the age of 19. Benefits under this endorsement terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the Policy terminates.

## Section 1: Accessing Pediatric Dental Services

### Network and Out-of-Network Benefits

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

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

Insured Persons must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. The Insured Person can check the participation status by calling the Company and/or the provider. The Company can help in referring the Insured Person to Network Dental Providers.

The Company will make a *Directory of Network Dental Providers* available to the Insured Person. The Insured Person can also call the Company at the number stated on their identification (ID) card to determine which providers participate in the Network.

**Out-of-Network Benefits** - these benefits apply when the Insured Person decides to obtain Covered Dental Services from out-of-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary Fee in the relevant geographic area for each Covered Dental Service. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. Insured Persons may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. When the Insured Person obtains Covered Dental Services from out-of-Network Dental Providers, the Insured Person may elect to allow the provider to submit the claim on their behalf. The Insured Person will be responsible for any service or material charges not covered under this endorsement.

### What Are Covered Dental Services?

The Insured Person is eligible for benefits for Covered Dental Services listed in this endorsement if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

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

## What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, the Insured Person may notify the Company of such treatment before treatment begins and receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

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

## Does Pre-Authorization Apply?

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

### Section 2: Benefits for Pediatric Dental Services

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

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

Benefits for Covered Dental Services are subject to satisfaction of the Dental Services Deductible.

**Network Benefits:**

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge the Insured Person or the Company for any service or supply that is not Necessary. If the Insured Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Insured Person. However, these charges will not be considered Covered Dental Services and benefits will not be payable.

**Out-of-Network Benefits:**

Benefits for Allowed Dental Amounts from out-of-Network providers are determined as a percentage of the Usual and Customary Fees. The Insured Person must pay the amount by which the out-of-Network provider's billed charge exceeds the Allowed Dental Amounts.

**Dental Services Deductible**

Benefits for pediatric Dental Services provided under this endorsement are not subject to the Policy Deductible stated in the Policy *Schedule of Benefits*. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible.

For any combination of Network and out-of-Network Benefits, the Dental Services Deductible per Policy Year is $500 per Insured Person.

**Out-of-Pocket Maximum** - any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*.

### Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

## Benefit Description

| **Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.** | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| **Diagnostic Services - (Subject to payment of the Dental Services Deductible.)** | | |
| *Evaluations (Checkup Exams)*<br><br>Limited to 2 times per 12 months.<br><br>Covered as a separate benefit only if no other service was done during the visit other than X-rays.<br>D0120 - Periodic oral evaluation<br>D0140 - Limited oral evaluation - problem focused<br>D9995 - Teledentistry - synchronous - real time encounter<br>D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review<br>D0150 - Comprehensive oral evaluation - new or established patient<br>D0180 - Comprehensive periodontal evaluation - new or established patient<br><br>The following service is not subject to a frequency limit.<br><br>D0160 - Detailed and extensive oral evaluation - problem focused, by report | 50% | 50% |
| *Intraoral Radiographs (X-ray)*<br><br>Limited to 2 series of films per 12 months.<br><br>D0210 - Intraoral complete series of radiographic images<br><br>D0709 - Intraoral - complete series of radiographic images - image capture only | 50% | 50% |
| The following services are not subject to a frequency limit. | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D0220 - Intraoral - periapical first radiographic image<br>D0230 - Intraoral - periapical - each additional radiographic image<br>D0240 - Intraoral - occlusal radiographic image<br>D0706 - Intraoral - occlusal radiographic image - image capture only<br>D0707 - Intraoral - periapical radiographic image - image capture only | | |
| Any combination of the following services is limited to 2 series of films per 12 months.<br><br>D0270 - Bitewing - single radiographic image<br>D0272 - Bitewings - two radiographic images<br>D0274 - Bitewings - four radiographic images<br>D0277 - Vertical bitewings - 7 to 8 radiographic images<br>D0708 - Intraoral - bitewing radiographic image - image capture only | 50% | 50% |
| Limited to 1 time per 36 months.<br><br>D0330 - Panoramic radiograph image<br>D0701 - Panoramic radiographic image - image capture only.<br>D0702 - 2-D Cephalometric radiographic image - image capture only<br>D0704 - 3-D Photographic image - image capture only | 50% | 50% |
| The following service is limited to 2 images per 12 months.<br><br>D0705 - Extra-oral posterior dental radiographic image - image capture only | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis<br>D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally<br>D0470 - Diagnostic casts<br>D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only | 50% | 50% |
| Preventive Services - (Subject to payment of the Dental Services Deductible.) | | |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| *Dental Prophylaxis (Cleanings)*<br><br>The following services are limited to 2 times every 12 months.<br><br>D1110 - Prophylaxis - adult<br>D1120 - Prophylaxis - child | 50% | 50% |
| *Fluoride Treatments*<br><br>The following services are limited to 2 times every 12 months.<br><br>D1206 - Topical application of fluoride varnish<br>D1208 - Topical application of fluoride - excluding varnish | 50% | 50% |
| *Sealants (Protective Coating)*<br><br>The following services are limited to once per first or second permanent molar every 36 months.<br><br>D1351 - Sealant<br>D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth | 50% | 50% |
| *Space Maintainers (Spacers)*<br><br>The following services are not subject to a frequency limit.<br><br>D1510 - Space maintainer - fixed - unilateral - per quadrant<br>D1516 - Space maintainer - fixed - bilateral maxillary<br>D1517 - Space maintainer - fixed - bilateral mandibular<br>D1520 - Space maintainer - removable - unilateral - per quadrant<br>D1526 - Space maintainer - removable - bilateral maxillary<br>D1527 - Space maintainer - removable - bilateral mandibular<br>D1551 - Re-cement or re-bond bilateral space maintainer - maxillary<br>D1552 - Re-cement or re-bond bilateral space maintainer - mandibular<br>D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant<br>D1556 - Removal of fixed unilateral space maintainer - per quadrant<br>D1557 - Removal of fixed bilateral space maintainer - maxillary<br>D1558 - Removal of fixed bilateral space maintainer - mandibular | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant | | |
| Minor Restorative Services - (Subject to payment of the Dental Services Deductible.) | | |
| *Amalgam Restorations (Silver Fillings)*<br><br>The following services are not subject to a frequency limit.<br><br>D2140 - Amalgams - one surface, primary or permanent<br>D2150 - Amalgams - two surfaces, primary or permanent<br>D2160 - Amalgams - three surfaces, primary or permanent<br>D2161 - Amalgams - four or more surfaces, primary or permanent | 50% | 50% |
| *Composite Resin Restorations (Tooth Colored Fillings)*<br><br>The following services are not subject to a frequency limit.<br><br>D2330 - Resin-based composite - one surface, anterior<br>D2331 - Resin-based composite - two surfaces, anterior<br>D2332 - Resin-based composite - three surfaces, anterior<br>D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior) | 50% | 50% |
| Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are subject to a limit of 1 time every 60 months.<br><br>D2542 - Onlay - metallic - two surfaces<br>D2543 - Onlay - metallic - three surfaces<br>D2544 - Onlay - metallic - four or more surfaces<br>D2740 - Crown - porcelain/ceramic<br>D2750 - Crown - porcelain fused to high noble metal<br>D2751 - Crown - porcelain fused to predominately base metal<br>D2752 - Crown - porcelain fused to noble metal<br>D2753 - Crown - porcelain fused to titanium and titanium alloys<br>D2780 - Crown - 3/4 cast high noble metal<br>D2781 - Crown - 3/4 cast predominately base metal<br>D2783 - Crown - 3/4 porcelain/ceramic | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D2790 - Crown - full cast high noble metal<br>D2791 - Crown - full cast predominately base metal<br>D2792 - Crown - full cast noble metal<br>D2794 - Crown - titanium and titanium alloys<br>D2930 - Prefabricated stainless steel crown - primary tooth<br>D2931 - Prefabricated stainless steel crown - permanent tooth<br><br>The following services are not subject to a frequency limit.<br><br>D2510 - Inlay - metallic - one surface<br>D2520 - Inlay - metallic - two surfaces<br>D2530 - Inlay - metallic - three surfaces<br>D2910 - Re-cement or re-bond inlay<br>D2920 - Re-cement or re-bond crown | | |
| The following service is not subject to a frequency limit.<br><br>D2940 - Protective restoration | 50% | 50% |
| The following services are limited to 1 time per tooth every 60 months.<br><br>D2929 - Prefabricated porcelain/ceramic crown - primary tooth<br>D2950 - Core buildup, including any pins when required | 50% | 50% |
| The following service is limited to 1 time per tooth every 60 months.<br><br>D2951 - Pin retention - per tooth, in addition to restoration | 50% | 50% |
| The following service is not subject to a frequency limit.<br><br>D2954 - Prefabricated post and core in addition to crown | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D2980 - Crown repair necessitated by restorative material failure<br>D2981 - Inlay repair necessitated by restorative material failure<br>D2982 - Onlay repair necessitated by restorative material failure | 50% | 50% |
| Endodontics - (Subject to payment of the Dental Services Deductible.) | | |
| The following service is not subject to a frequency limit. | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D3220 - Therapeutic pulpotomy (excluding final restoration) | | |
| The following service is not subject to a frequency limit.<br><br>D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration)<br>D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D3310 - Endodontic therapy anterior tooth (excluding final restoration)<br>D3320 - Endodontic therapy premolar tooth (excluding final restoration)<br>D3330 - Endodontic therapy molar tooth (excluding final restoration)<br>D3346 - Retreatment of previous root canal therapy - anterior<br>D3347 - Retreatment of previous root canal therapy - bicuspid<br>D3348 - Retreatment of previous root canal therapy - molar | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D3351 - Apexification/recalcification - initial visit<br>D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement<br>D3353 - Apexification/recalcification - final visit | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D3410 - Apicoectomy - anterior<br>D3421 - Apicoectomy - premolar (first root)<br>D3425 - Apicoectomy- molar (first root)<br>D3426 - Apicoectomy- (each additional root)<br>D3450 - Root amputation - per root<br>D3471 - Surgical repair of root resorption - anterior | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D3472 - Surgical repair of root resorption - premolar<br>D3473 - Surgical repair of root resorption - molar<br>D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior<br>D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar<br>D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar | | |
| The following services are not subject to a frequency limit.<br><br>D3911 - Intraorifice barrier<br>D3920 - Hemisection (including any root removal), not including root canal therapy | 50% | 50% |
| Periodontics - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are limited to a frequency of 1 every 36 months.<br><br>D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant<br>D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | 50% | 50% |
| The following services are limited to 1 every 36 months.<br><br>D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant<br>D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant<br>D4249 - Clinical crown lengthening - hard tissue | 50% | 50% |
| The following services are limited to 1 every 36 months.<br><br>D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant<br>D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D4263 - Bone replacement graft retained natural tooth - first site- in quadrant | | |
| The following service is not subject to a frequency limit.<br><br>D4270 - Pedicle soft tissue graft procedure | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft<br>D4275 - Non-autogenous connective tissue graft first tooth implant<br>D4277 - Free soft tissue graft procedure - first tooth<br>D4278 - Free soft tissue graft procedure - each additional contiguous tooth<br>D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns<br>D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns | 50% | 50% |
| The following services are limited to 1 time per quadrant every 24 months.<br><br>D4341 - Periodontal scaling and root planing - four or more teeth per quadrant<br>D4342 - Periodontal scaling and root planing - one to three teeth per quadrant<br>D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation | 50% | 50% |
| The following service is limited to a frequency to 1 per lifetime.<br><br>D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit | 50% | 50% |
| The following service is limited to 4 times every 12 months in combination with prophylaxis.<br><br>D4910 - Periodontal maintenance | 50% | 50% |
| Removable Dentures - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are limited to a frequency of 1 every 60 months.<br><br>D5110 - Complete denture - maxillary<br>D5120 - Complete denture - mandibular | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D5130 - Immediate denture - maxillary<br>D5140 - Immediate denture - mandibular<br>D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)<br>D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)<br>D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)<br>D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)<br>D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)<br>D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)<br>D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)<br>D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)<br>D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth)<br>D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth)<br>D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary<br>D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular<br>D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant | | |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant | | |
| The following services are not subject to a frequency limit.<br><br>D5410 - Adjust complete denture - maxillary<br>D5411 - Adjust complete denture - mandibular<br>D5421 - Adjust partial denture - maxillary<br>D5422 - Adjust partial denture - mandibular<br>D5511 - Repair broken complete denture base - mandibular<br>D5512 - Repair broken complete denture base - maxillary<br>D5520 - Replace missing or broken teeth - complete denture (each tooth)<br>D5611 - Repair resin partial denture base - mandibular<br>D5612 - Repair resin partial denture base - maxillary<br>D5621 - Repair cast partial framework - mandibular<br>D5622 - Repair cast partial framework - maxillary<br>D5630 - Repair or replace broken retentive/clasping materials - per tooth<br>D5640 - Replace broken teeth - per tooth<br>D5650 - Add tooth to existing partial denture<br>D5660 - Add clasp to existing partial denture | 50% | 50% |
| The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months.<br><br>D5710 - Rebase complete maxillary denture<br>D5711 - Rebase complete mandibular denture<br>D5720 - Rebase maxillary partial denture<br>D5721 - Rebase mandibular partial denture<br>D5725 - Rebase hybrid prosthesis<br>D5730 - Reline complete maxillary denture (direct)<br>D5731 - Reline complete mandibular denture (direct) | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D5740 - Reline maxillary partial denture (direct)<br>D5741 - Reline mandibular partial denture (direct)<br>D5750 - Reline complete maxillary denture (indirect)<br>D5751 - Reline complete mandibular denture (indirect)<br>D5760 - Reline maxillary partial denture (indirect)<br>D5761 - Reline mandibular partial denture (indirect)<br>D5876 - Add metal substructure to acrylic full denture (per arch) | | |
| The following services are not subject to a frequency limit.<br><br>D5765 - Soft liner for complete or partial removable denture - indirect<br>D5850 - Tissue conditioning (maxillary)<br>D5851 - Tissue conditioning (mandibular) | 50% | 50% |
| Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are not subject to a frequency limit.<br><br>D6210 - Pontic - cast high noble metal<br>D6211 - Pontic - cast predominately base metal<br>D6212 - Pontic - cast noble metal<br>D6214 - Pontic - titanium and titanium alloys<br>D6240 - Pontic - porcelain fused to high noble metal<br>D6241 - Pontic - porcelain fused to predominately base metal<br>D6242 - Pontic - porcelain fused to noble metal<br>D6243 - Pontic - porcelain fused to titanium and titanium alloys<br>D6245 - Pontic - porcelain/ceramic | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D6545 - Retainer - cast metal for resin bonded fixed prosthesis<br>D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis | 50% | 50% |
| The following services are limited to 1 time every 60 months.<br><br>D6740 - Retainer crown - porcelain/ceramic<br>D6750 - Retainer crown - porcelain fused to high noble metal | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D6751 - Retainer crown - porcelain fused to predominately base metal<br>D6752 - Retainer crown - porcelain fused to noble metal<br>D6753 - Retainer crown - porcelain fused to titanium and titanium alloys<br>D6780 - Retainer crown - 3/4 cast high noble metal<br>D6781 - Retainer crown - 3/4 cast predominately base metal<br>D6782 - Retainer crown - 3/4 cast noble metal<br>D6783 - Retainer crown - 3/4 porcelain/ceramic<br>D6784 - Retainer crown - 3/4 titanium and titanium alloys<br>D6790 - Retainer crown - full cast high noble metal<br>D6791 - Retainer crown - full cast predominately base metal<br>D6792 - Retainer crown - full cast noble metal | | |
| The following service is not subject to a frequency limit.<br><br>D6930 - Re-cement or re-bond FPD | 50% | 50% |
| The following service is not subject to a frequency limit.<br><br>D6980 - FPD repair necessitated by restorative material failure | 50% | 50% |
| Oral Surgery - (Subject to payment of the Dental Services Deductible.) | | |
| The following service is not subject to a frequency limit.<br><br>D7140 - Extraction, erupted tooth or exposed root | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated<br>D7220 - Removal of impacted tooth - soft tissue<br>D7230 - Removal of impacted tooth - partially bony<br>D7240 - Removal of impacted tooth - completely bony<br>D7241 - Removal of impacted tooth - completely bony with unusual surgical complications<br>D7250 - Surgical removal or residual tooth roots | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D7251 - Coronectomy - intentional partial tooth removal | | |
| The following service is not subject to a frequency limit.<br><br>D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | 50% | 50% |
| The following service is not subject to a frequency limit.<br><br>D7280 - Surgical access exposure of an unerupted tooth | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant<br>D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant<br>D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant<br>D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant | 50% | 50% |
| The following service is not subject to a frequency limit.<br><br>D7471 - Removal of lateral exostosis (maxilla or mandible) | 50% | 50% |
| The following services are not subject to a frequency limit.<br><br>D7510 - Incision and drainage of abscess, intraoral soft tissue<br>D7910 - Suture of recent small wounds up to 5 cm<br>D7953 - Bone replacement graft for ridge preservation - per site<br>D7961 - Buccal/labial frenectomy (frenulectomy)<br>D7962 - Lingual frenectomy (frenulectomy)<br>D7971 - Excision of pericoronal gingiva | 50% | 50% |
| Adjunctive Services - (Subject to payment of the Dental Services Deductible.) | | |
| The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D9110 - Palliative (Emergency) treatment of dental pain - minor procedure | | |
| Covered only when clinically Necessary.<br><br>D9222 - Deep sedation/general anesthesia - first 15 minutes<br>D9223 - Deep sedation/general anesthesia - each 15 minute increment<br>D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes<br>D9610 - Therapeutic parenteral drug single administration | 50% | 50% |
| Covered only when clinically Necessary<br><br>D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment) | 50% | 50% |
| The following is limited to 1 guard every 12 months.<br><br>D9944 - Occlusal guard - hard appliance, full arch<br>D9945 - Occlusal guard - soft appliance, full arch<br>D9946 - Occlusal guard - hard appliance, partial arch | 50% | 50% |
| Implant Procedures - (Subject to payment of the Dental Services Deductible.) | | |
| The following services are limited to 1 time every 60 months.<br><br>D6010 - Surgical placement of implant body: endosteal implant<br>D6012 - Surgical placement of interim implant body<br>D6040 - Surgical placement of eposteal implant<br>D6050 - Surgical placement: transosteal implant<br>D6055 - Connecting bar - implant supported or abutment supported<br>D6056 - Prefabricated abutment - includes modification and placement<br>D6057 - Custom fabricated abutment - includes placement<br>D6058 - Abutment supported porcelain/ceramic crown<br>D6059 - Abutment supported porcelain fused to metal crown (high noble metal) | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D6060 - Abutment supported porcelain fused to metal crown (predominately base metal)<br>D6061 - Abutment supported porcelain fused to metal crown (noble metal)<br>D6062 - Abutment supported cast metal crown (high noble metal)<br>D6063 - Abutment supported cast metal crown (predominately base metal)<br>D6064 - Abutment supported cast metal crown (noble metal)<br>D6065 - Implant supported porcelain/ceramic crown<br>D6066 - Implant supported crown - porcelain fused to high noble alloys<br>D6067 - Implant supported crown - high noble alloys<br>D6068 - Abutment supported retainer for porcelain/ceramic FPD<br>D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal)<br>D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)<br>D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal)<br>D6072 - Abutment supported retainer for cast metal FPD (high noble metal)<br>D6073 - Abutment supported retainer for cast metal FPD (predominately base metal)<br>D6074 - Abutment supported retainer for cast metal FPD (noble metal)<br>D6075 - Implant supported retainer for ceramic FPD<br>D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys<br>D6077 - Implant supported retainer for metal FPD - high noble alloys<br>D6080 - Implant maintenance procedure<br>D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure<br>D6082 - Implant supported crown - porcelain fused to predominantly base alloys<br>D6083 - Implant supported crown - porcelain fused to noble alloys | | |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys<br>D6086 - Implant supported crown - predominantly base alloys<br>D6087 - Implant supported crown - noble alloys<br>D6088 - Implant supported crown - titanium and titanium alloys<br>D6090 - Repair implant supported prosthesis, by report<br>D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment<br>D6095 - Repair implant abutment, by report<br>D6096 - Remove broken implant retaining screw<br>D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys<br>D6098 - Implant supported retainer - porcelain fused to predominantly base alloys<br>D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys<br>D6100 - Surgical removal of implant body<br>D6101 - Debridement peri-implant defect<br>D6102 - Debridement and osseous contouring of a peri-implant defect<br>D6103 - Bone graft for repair of peri-implant defect<br>D6104 - Bone graft at time of implant replacement<br>D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular<br>D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary<br>D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys<br>D6121 - Implant supported retainer for metal FPD - predominantly base alloys<br>D6122 - Implant supported retainer for metal FPD - noble alloys<br>D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys<br>D6190 - Radiographic/surgical implant index, by report<br>D6191 - Semi-precision abutment - placement | | |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D6192 - Semi-precision attachment - placement<br>D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys | | |
| Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.) | | |
| Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.<br><br>All orthodontic treatment must be prior authorized.<br><br>Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.<br><br>Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary. | | |
| The following services are not subject to a frequency limitation as long as benefits have been prior authorized.<br><br>D8010 - Limited orthodontic treatment of the primary dentition<br>D8020 - Limited orthodontic treatment of the transitional dentition<br>D8030 - Limited orthodontic treatment of the adolescent dentition<br>D8070 - Comprehensive orthodontic treatment of the transitional dentition<br>D8080 - Comprehensive orthodontic treatment of the adolescent dentition<br>D8210 - Removable appliance therapy<br>D8220 - Fixed appliance therapy<br>D8660 - Pre-orthodontic treatment visit<br>D8670 - Periodic orthodontic treatment visit<br>D8680 - Orthodontic retention<br>D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment<br>D8696 - Repair of orthodontic appliance - maxillary<br>D8697 - Repair of orthodontic appliance - mandibular<br>D8698 - Re-cement or re-bond fixed retainer - maxillary<br>D8699 - Re-cement or re-bond fixed retainer - mandibular | 50% | 50% |

| Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts. | | |
|---|---|---|
| **What Are the Procedure Codes, Benefit Description and Frequency Limitations?** | **Network Benefits** | **Out-of-Network Benefits** |
| D8701 - Repair of fixed retainer, includes reattachment - maxillary<br>D8702 - Repair of fixed retainer, includes reattachment - mandibular | | |

## Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this endorsement under *Section 2: Benefits for Covered Dental Services*, benefits are not provided under this endorsement for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this endorsement in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this endorsement to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person’s family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

## Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from an out-of-Network Dental Provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider unless the Company has received a written request from the Insured Person stating to pay the Dental Provider directly. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

## Reimbursement for Dental Services

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

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

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

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

UnitedHealthcare Dental
ATTN: Claims Unit
P. O. Box 30567
Salt Lake City, UT 84130-0567

If the Insured Person would like to use a claim form, call Customer Service at the number listed on the Insured's Dental ID Card. If the Insured Person does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.

## Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in the Definitions section of the Certificate of Coverage:

**Allowed Dental Amounts** - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

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

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

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

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

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

**Dental Services Deductible** - the amount the Insured Person must pay for Covered Dental Services in a Policy Year before the Company will begin paying for Network or Out-of-Network Benefits in that Policy Year.

**Experimental, Investigational, or Unproven Service** - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time is determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

**Foreign Services** - services provided outside the U.S. and U.S. Territories.

**Necessary** - Dental Services and supplies under this endorsement which are determined to match approved version based on accepted dental practices to be appropriate and are all of the following:

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

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

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

**Network** - a group of Dental Providers who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Insured Persons. The participation status of providers will change from time to time.

**Network Benefits** - benefits available for Covered Dental Services when provided by a Dental Provider who is a Network Dentist.

**Out-of-Network Benefits** - benefits available for Covered Dental Services obtained from out-of-Network Dentists.

**Usual and Customary Fee** - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees (data provided from FAIR Health, Inc.) in the geographic area in which the service is rendered and are calculated at the 80th percentile.

Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services. The Usual and Customary Fee will never be less than the Allowed Dental Amount.The Insured Person is responsible for any amount billed for a health care service or supply that exceeds the amount of final payment.

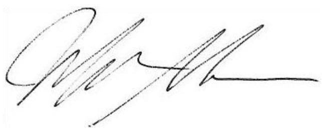
Usual and Customary Fees are determined in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

**This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all the terms and conditions of the Policy not inconsistent therewith.**



**President**

**It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:**

## Pediatric Vision Care Services Benefits

Benefits are provided under this endorsement for Vision Care Services, as described below, for Insured Persons under the age of 19. Benefits under this endorsement terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the Policy terminates.

### Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network or an out-of-Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, the Insured Person may call the provider locator service at 1-800-839-3242. The Insured Person may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhcvision.com.

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

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

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

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

**Out-of-Pocket Maximum** - any amount the Insured Person pays in Coinsurance for Vision Care Services under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*. Any amount the Insured Person pays in Copayments for Vision Care Services under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*.

**Policy Deductible**
Benefits for pediatric Vision Care Services provided under this endorsement are not subject to any Policy Deductible stated in the Policy *Schedule of Benefits.* Any amount the Insured Person pays in Copayments for Vision Care Services under this endorsement does not apply to the Policy Deductible stated in the Policy *Schedule of Benefits*.

## What Are the Benefit Descriptions?

### Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

### Frequency of Service Limits

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

### Routine Vision Examination

A routine vision examination of the eyes and according to the standards of care in the area where the Insured Person resides, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) – helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation – how well the Insured Person sees up close (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

### Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

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

If the Insured Person purchases Eyeglass Lenses and Eyeglass Frames at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

### Eyeglass Frames

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

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

If the Insured Person purchases Eyeglass Lenses and Eyeglass Frames at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

**Contact Lenses**

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

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

**Necessary Contact Lenses**

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company.

Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

**Low Vision**

Benefits are available to Insured Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by the Company.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive exam of visual functions.
  - The prescription of corrective eyewear or vision aids where indicated.
  - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.

## Schedule of Benefits

| Vision Care Service | What is the Frequency of Service? | Network Benefit | Out-of-Network Benefit |
|---|---|---|---|
| **Routine Vision Examination or Refraction only in lieu of a complete exam** | Once per year. | 100% after a Copayment of $20. | 50% of the billed charge. |
| **Eyeglass Lenses** | Once per year. | | |
| • Single Vision | | 100% after a Copayment of $40. | 50% of the billed charge. |
| • Bifocal | | 100% after a Copayment of $40. | 50% of the billed charge. |

| Vision Care Service | What is the Frequency of Service? | Network Benefit | Out-of-Network Benefit |
|---|---|---|---|
| • Trifocal | | 100% after a Copayment of $40. | 50% of the billed charge. |
| • Lenticular | | 100% after a Copayment of $40. | 50% of the billed charge. |
| **Lens Extras** | Once per year. | | |
| • Polycarbonate lenses | | 100% | 100% of the billed charge. |
| • Standard scratch-resistant coating | | 100% | 100% of the billed charge. |

| Vision Care Service | What is the Frequency of Service? | Network Benefit | Out-of-Network Benefit |
|---|---|---|---|
| **Eyeglass Frames** | Once per year. | | |
| • Eyeglass frames with a retail cost up to $130. | | 100% | 50% of the billed charge. |
| • Eyeglass frames with a retail cost of $130 - $160. | | 100% after a Copayment of $15. | 50% of the billed charge. |
| • Eyeglass frames with a retail cost of $160 - $200. | | 100% after a Copayment of $30. | 50% of the billed charge. |
| • Eyeglass frames with a retail cost of $200 - $250. | | 100% after a Copayment of $50. | 50% of the billed charge. |
| • Eyeglass frames with a retail cost greater than $250. | | 60% | 50% of the billed charge. |

| Vision Care Service | What is the Frequency of Service? | Network Benefit | Out-of-Network Benefit |
|---|---|---|---|
| **Contact Lenses Fitting & Evaluation** | Once per year. | 100% | 100% of the billed charge. |
| **Contact Lenses** | | | |
| • Covered Contact Lens Selection | Limited to a 12 month supply. | 100% after a Copayment of $40. | 50% of the billed charge. |
| • Necessary Contact Lenses | Limited to a 12 month supply. | 100% after a Copayment of $40. | 50% of the billed charge. |

| Vision Care Service | What is the Frequency of Service? | Network Benefit | Out-of-Network Benefit |
|---|---|---|---|
| **Low Vision Care Services** Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated. | Once every 24 months. | | |
| • Low vision testing | | 100% of the billed charge. | 75% of the billed charge. |

| | | | |
|---|---|---|---|
| • Low vision therapy | | 100% of the billed charge. | 75% of the billed charge. |

## Section 2: Pediatric Vision Exclusions

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

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

## Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider unless the Company has received a written request from the Insured Person stating to pay the Vision Care Provider directly.The Insured Person may then seek reimbursement from the Company. Information about claim timelines and responsibilities in the General Provisions section in the Certificate of Coverage applies to Vision Care Services provided under this endorsement, except that when the Insured Person submits a Vision Services claim, the Insured Person must provide the Company with all of the information identified below.

### Reimbursement for Vision Care Services

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

- Insured Person’s itemized receipts.
- Insured Person's name.
- Insured Person's identification number from the ID card.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):
248-733-6060

## Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in Definitions section of the Certificate of Coverage:

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

**UnitedHealthcare Vision Network** - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the Policy.

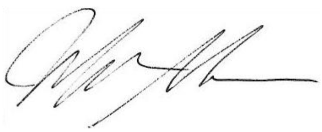
**Vision Care Provider** - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

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

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

**This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all of the terms and conditions of the Policy not inconsistent therewith.**



**President**

**It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:**

## UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

### When are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products when dispensed at a UHCP Network Pharmacy as specified in the Policy Schedule of Benefits subject to all terms of the Policy and the provisions, definitions and exclusions specified in this endorsement.

Benefits for Prescription Drug Products are subject to supply limits and Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the Policy Schedule of Benefits for applicable supply limits and Copayments and/or Coinsurance requirements.

Benefit for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Medical Expense.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after ¾ of the original Prescription Drug Product has been used. For select controlled medications filled at a retail Network Pharmacy, refills are available when 90% of the original Prescription Drug Product has been used. For select controlled medications filled at a mail order Network Pharmacy, refills are available when 80% of the original Prescription Drug Product has been used.

The Insured must either show their ID card to the Network Pharmacy when the prescription is filled or provide the Network Pharmacy with identifying information that can be verified by the Company during regular business hours. If the Insured does not show their ID card to the Network Pharmacy or provide verifiable information, they will need to pay for the Prescription Drug at the pharmacy.

The Insured may then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting www.uhcsr.com/uaf and logging in to their online account or by calling *Customer Service* at 1-855-828-7716.

Information on Network Pharmacies is available at www.uhcsr.com/uaf or by calling *Customer Service* at 1-855-828-7716.

Benefits are also available for Prescription Drugs when dispensed at an out-of-network pharmacy as described in the Certificate of Coverage. When prescriptions are filled at pharmacies outside a Network Pharmacy, the Insured must pay for the Prescription Drugs out of pocket and submit the receipts for reimbursement as described in the How to File a Claim for Injury and Sickness Benefits section in the Certificate of Coverage.

### Copayment and/or Coinsurance Amount

For Prescription Drug Products at a retail Network Pharmacy, Insured Persons are responsible for paying the lowest of:

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.

- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance; or
- The Prescription Drug Charge for that Prescription Drug Product.

The Insured Person is not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

## How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size. For a single Copayment and/or Coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject, from time to time, to the Company's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

The Insured may find out whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing at www.uhcsr.com/uaf or by calling *Customer Service* at 1-855-828-7716.

## What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

## What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular reference product.

## Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If the Insured requires Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Specialty Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and the Insured has informed the Company of their decision not to obtain their Specialty Prescription Drug Product from a Designated Pharmacy, and the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

The Company designates certain Network Pharmacies to be Preferred Specialty Network Pharmacies. The Company may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to the Insured unless required by law. The Insured may find out whether a Network Pharmacy is a Preferred Specialty Network Pharmacy at www.uhcsr.com/uaf or by calling *Customer Service* at 1-855-828-7716.

Please see the Definitions Section for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The following supply limits apply to Specialty Prescription Drug Products.
As written by the Physician, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

## Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Insured's Physician, Insured's pharmacist or the Insured is required to obtain prior authorization from the Company or the Company's designee. The reason for obtaining prior authorization from the Company is to determine whether the Prescription Drug Product, in accordance with the Company's approved guidelines, is each of the following:

- It meets the definition of a Covered Medical Expense.
- It is not an Experimental or Investigational or Unproven Service.

If the Insured does not obtain prior authorization from the Company before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring prior authorization are subject, from time to time, to the Company's review and change. There may be certain Prescription Drug Products that require the Insured to notify the Company directly rather than the Insured's Physician or pharmacist. The Insured may determine whether a particular Prescription Drug requires prior authorization at www.uhcsr.com/uaf or by calling *Customer Service* at 1-855-828-7716.

If the Insured does not obtain prior authorization from the Company before the Prescription Drug Product is dispensed, the Insured will be required to pay for the Prescription Drug Product at the pharmacy. The Insured can submit their claim for consideration and ask the Company to consider reimbursement after the Insured receives the Prescription Drug Product.

When the Insured submits a claim on this basis and the claim is eligible for reimbursement, the amount the Insured is reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any Deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Company reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Medical Expense or it is an Experimental or Investigational or Unproven Service.

## Does Step Therapy Apply?

Certain Prescription Drug Products for which benefits are provided are subject to step therapy requirements. In order to receive benefits for such Prescription Drug Products an Insured must use a different Prescription Drug Product(s) first.

The Insured may find out whether a Prescription Drug Product is subject to step therapy requirements at www.uhcsr.com/uaa or by calling *Customer Service* at 1-855-828-7716.

## Coverage Policies and Guidelines

The Company's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Company's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others, therefore; a Prescription Drug may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

The Company may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may happen without prior notice to the Insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. Please access www.uhcsr.com/uaf or call *Customer Service* at 1-855-828-7716 for the most up-to-date tier placement.

## Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company does not pass these rebates on to the Insured Person, nor are they applied to the Insured's Deductible or taken into account in determining the Insured's Copayments and/or Coinsurance.

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Endorsement. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

## Definitions

**Brand-name** means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician will be classified as Brand-name by the Company.

**Chemically Equivalent** means when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy** means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Specialty Prescription Drug Products. Not all Network Pharmacies are a Designated Pharmacy.

**Experimental or Investigational Services** means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which benefits are specifically provided for in the Policy.
- If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the Policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for

that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

**Generic** means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician will be classified as a Generic by the Company.

**Maintenance Medication** means a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. The Insured may find out if a Prescription Drug Product is a Maintenance Medication at www.uhcsr.com/uaf or by calling *Customer Service* at 1-855-828-7716.

**Network Pharmacy** means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on the Company's behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

**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 placed on a tier by the Company's PDL Management Committee.
- December 31st of the following calendar year.

**Non-Preferred Specialty Network Pharmacy** means a specialty Network Pharmacy that the Company identifies as a non-preferred pharmacy within the network.

**PPACA** means Patient Protection and Affordable Care Act of 2010.

**PPACA Zero Cost Share Preventive Care Medications** means the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, or Deductible) as required by applicable law under any of the following:

- 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.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Insured may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives at www.uhcsr.com/uaf or by calling *Customer Service* at 1-855-828-7716.

**Preferred 90 Day Retail Network Pharmacy** means a retail pharmacy that the Company identifies as a preferred pharmacy within the network for Maintenance Medication.

**Preferred Specialty Network Pharmacy** means a specialty Network Pharmacy that the Company identifies as a preferred pharmacy within the network.

**Prescription Drug Charge** means the rate the Company has agreed to pay the Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes a dispensing fee and any applicable sales tax.

**Prescription Drug List** means a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's review and change from time to time (no more than one time per calendar year on the Policy effective date). The Insured may find out which tier a particular Prescription Drug Product has been placed at www.uhcsr.com/uaf or call *Customer Service* at 1-855-828-7716.

**Prescription Drug List (PDL) Management Committee** means the committee that the Company designates for placing Prescription Drugs into specific tiers.

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

- Inhalers.
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

**Prescription Order or Refill** means the directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

**Specialty Prescription Drug Product** means Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products at www.uhcsr.com/uaf or call *Customer Service* at 1-855-828-7716.

**Therapeutically Equivalent** means when Prescription Drugs Products have essentially the same efficacy and adverse effect profile.

**Unproven Service(s)** means services, including medications, that are determined not to be effective for the treatment of the medical condition and/or not to have a beneficial effect on the health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Company has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Company issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, as it determines, consider an otherwise Unproven Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

**Usual and Customary Fee** means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties and is consistent with applicable state health claims standards requiring equal to or greater than the 80th percentile of the charge. This fee includes a dispensing fee and any applicable sales tax.

## Additional Exclusions

In addition to the Exclusions and Limitations shown in the Certificate of Coverage, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
4. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined to be experimental, investigational or unproven.

5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
8. General vitamins, except the following, which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.
9. Certain unit dose packaging or repackagers of Prescription Drug Products.
10. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Medical Expense.
11. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.
12. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. 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 placed on Tier-3.)
13. 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 made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made no more than six times per calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
14. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate.
15. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made no more than six times per calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
16. 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. Such determinations may be made no more than one time per calendar year on the Policy effective date, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
17. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made no more than one time per calendar year on the Policy effective date, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
18. A Prescription Drug Product with either:
   - An approved biosimilar.
   - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

   For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
   - It is highly similar to a reference product (a biological Prescription Drug Product).
   - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made no more than one time per calendar year on the Policy effective date. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
19. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
20. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
21. Diagnostic kits and products, including associated services.
22. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

23. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product

**Right to Request an Exclusion Exception**

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-866-808-8266. The Company will notify the Insured Person of the Company's determination within 72 hours.

Please note, if the request for an exception is approved, the Insured may be responsible for paying the applicable Copayment and/or Coinsurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the Schedule of Benefits.

**Urgent Requests**

If the Insured Person's request requires immediate action and a delay could significantly increase the risk to the Insured Person's health, or the ability to regain maximum function, call the Company as soon as possible. The Company will provide a written or electronic determination within 24 hours.

**External Review**

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-866-808-8266. The *Independent Review Organization (IRO)* will notify the Insured Person of the determination within 72 hours.

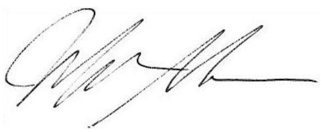
**Expedited External Review**

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-866-808-8266 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

**This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all of the terms and conditions of the Policy not inconsistent therewith.**



**President**

**It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:**

An Insured Person under this insurance plan is eligible for Assistance and Evacuation Benefits in addition to the underlying plan coverage. The requirements to receive these benefits are as follows:

International Students, insured spouse or Domestic Partner and insured minor child(ren) are eligible to receive Assistance and Evacuation Benefits worldwide, except in their Home Country.

Domestic Students, insured spouse or Domestic Partner and insured minor child(ren) are eligible for Assistance and Evacuation Benefits when 100 miles or more away from their campus address or 100 miles or more away from their permanent home address or while participating in a study abroad program.

## Assistance and Evacuation Benefits

### DEFINITIONS

The following definitions apply to the Assistance and Evacuation Benefits described further below.

“Emergency Medical Event” means an event wherein an Insured Person’s medical condition and situation are such that, in the opinion of the Company’s affiliate or authorized vendor and the Insured Person’s treating physician, the Insured Person requires urgent medical attention without which there would be a significant risk of death, or serious impairment and adequate medical treatment is not available at the Insured Person’s initial medical facility.

“Home Country” means, with respect to an Insured Person, the country or territory as shown on the Insured Person’s passport or the country or territory of which the Insured Person is a permanent resident.

“Host Country” means, with respect to an Insured Person, the country or territory the Insured Person is visiting or in which the Insured Person is living, which is not the Insured Person’s Home Country.

“Physician Advisors” mean physicians retained by the Company’s affiliate or authorized vendor for provision of consultative and advisory services to the Company’s affiliate or authorized vendor, including the review and analysis of the medical care received by Insured Persons.

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An Insured Person should notify the Company’s affiliate or authorized vendor to obtain benefits for Medical Evacuation and Repatriation. If the Insured Person doesn’t notify the Company’s affiliate or authorized vendor, benefits will be limited to the amount that would have been paid if advance notice had been provided.

Medical Evacuation and Repatriation benefits are covered if needed due to an Insured’s Sickness or Injury.  Coverage for such services does not extend to circumstances where the need for evacuation, repatriation or other related services is not triggered by Injury or Sickness.  For example, coverage for a Medical Evacuation under this Endorsement does not extend to circumstances where an evacuation is needed due to a storm, security risk, epidemic, natural disaster or other similar circumstance.

## MEDICAL EVACUATION AND REPATRIATION BENEFITS

**Emergency Medical Evacuation:** If an Insured Person suffers a Sickness or Injury, experiences an Emergency Medical Event and adequate medical facilities are not available locally in the opinion of the *Medical Director* of the Company's affiliate or authorized vendor, the Company's affiliate or authorized vendor will provide an emergency medical evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the emergency medical evacuation.

**Dispatch of Doctors/Specialists:** If an Insured Person experiences an Emergency Medical Event and the Company's affiliate or authorized vendor determines that an Insured Person cannot be adequately assessed by telephone for possible medical evacuation from the initial medical facility or that the Insured Person cannot be moved and local treatment is unavailable, the Company's affiliate or authorized vendor will arrange to send an appropriate medical practitioner to the Insured Person's location when it deems it appropriate for medical management of a case. The Company will pay costs for transportation and expenses associated with dispatching a medical practitioner to an Insured Person's location, not including the costs of the medical practitioner's service.

**Medical Repatriation**: After an Insured Person receives initial treatment and stabilization for a Sickness or Injury, if the attending physician and the *Medical Director* of the Company's affiliate or authorized vendor determine that it is medically necessary, the Company's affiliate or authorized vendor will transport an Insured Person back to the Insured Person's permanent place of residence for further medical treatment or to recover. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

**Transportation after Stabilization:** If Medical Repatriation is not required following stabilization of the Insured Person's condition and discharge from the hospital, the Company's affiliate or authorized vendor will coordinate transportation to the Insured Person's point of origin, Home Country, or Host Country. The Company will pay costs for economy transportation (or upgraded transportation to match an Insured Person's originally booked travel arrangements) to the Insured Person's original point of origin, Home Country or Host Country.

**Transportation to Join a Hospitalized Insured Person:** If an Insured Person who is travelling alone is or will be hospitalized for more than three (3) days due to a Sickness or Injury, the Company's affiliate or authorized vendor will coordinate round-trip airfare for a person of the Insured Person's choice to join the Insured Person. The Company will pay costs for economy class round-trip airfare for a person to join the Insured Person.

**Return of Minor Children:** If an Insured Person's minor child(ren) age 18 or under are present but left unattended as a result of the Insured Person's Injury or Sickness, the Company's affiliate or authorized vendor will coordinate airfare to send them back to the Insured Person's Home Country. The Company's affiliate or authorized vendor will also arrange for the services, transportation expenses, and accommodations of a non-medical escort, if required as determined by the Company's affiliate or authorized vendor. The Company will pay costs for economy class one-way airfare for the minor children (or upgraded transportation to match the Insured Person's originally booked travel arrangement) and, if required, the cost of the services, transportation expenses, and accommodations of a non-medical escort to accompany the minor children back to the Insured Person's Home Country.

**Repatriation of Mortal Remains:** In the event of an Insured Person's death, the Company's affiliate or authorized vendor will assist in obtaining the necessary clearances for the Insured Person's cremation or the return of the Insured Person's mortal remains. The Company's affiliate or authorized vendor will coordinate the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence, as it obtains the number of certified death certificates required by the Host Country and Home Country to release and receive the remains. The Company will pay costs for the certified death certificates required by the Home Country or Host Country to release the remains and expenses of the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence.

## CONDITIONS AND LIMITATIONS

Assistance and Evacuation Benefits shall only be provided to an Insured Person after the Company's affiliate or authorized vendor receives the request (in writing or via phone) from the Insured Person or an authorized representative of the Insured Person of the need for the requested Assistance and Evacuation Benefits. Unless an Insured Person is incapacitated and unable to contact the Company's affiliate or authorized vendor during an Emergency Medical Event for benefits to be available, the requested Assistance and Evacuation Benefits services and payments must be arranged, authorized, verified and approved in advance by the Company's affiliate or authorized vendor. If an Insured Person is incapacitated and unable to immediately contact the Company's affiliate or authorized vendor due to an Emergency Medical Event, the Insured Person should notify the Company's affiliate or authorized vendor within 48 hours or as soon as reasonably possible.

With respect to any evacuation requested by an Insured Person, the Company's affiliate or authorized vendor shall evaluate the feasibility of an evacuation and the means, method, timing, and destination of such evacuation, and may consult with relevant third-parties, including as applicable, Physician Advisors and treating physicians as needed to make its determination.

In the event an Insured Person is incapacitated or deceased, his/her designated or legal representative shall have the right to act for and on behalf of the Insured Person.

The following Exclusions and Limitations apply to the Assistance and Evacuation Benefits.

In no event shall the Company be responsible for providing Assistance and Evacuation Benefits to an Insured Person in a situation arising from or in connection with any of the following:

1. Travel Assistance and Evacuation costs that were neither arranged nor approved in advance by the Company's affiliate or authorized vendor or, in the event of an Emergency Medical Event where the Insured Person was incapacitated and unable to seek prior authorization, where the Insured Person did not provide notification as soon as reasonably possible.
2. Taking part in military or police service operations.
3. Insured Person's failure to properly procure or maintain immigration, work, residence or similar type visas, permits or documents.
4. The actual or threatened use or release of any nuclear, chemical or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of contributory cause.
5. Any evacuation or repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
7. Medical Evacuations directly or indirectly related to a natural disaster.
8. Subsequent Medical Evacuations for the same or related Sickness, Injury or Emergency Medical Event regardless of location.

## Additional Assistance Services

The following assistance services will be available to an Insured Person in addition to the Assistance and Evacuation Benefits.

### MEDICAL ASSISTANCE SERVICES

**Worldwide Medical and Dental Referrals:** Upon an Insured Person's request, the Company's affiliate or authorized vendor will provide referrals to physicians, hospitals, dentists, and dental clinics in the area the Insured Person is traveling in order to assist the Insured Person in locating appropriate treatment and quality care.

**Monitoring of Treatment**: As and to the extent permissible, the Company's affiliate or authorized vendor will continually monitor the Insured Person's medical condition. Third-party medical providers may offer consultative and advisory services to the Company's affiliate or authorized vendor in relation to the Insured Person's medical condition, including review and analysis of the quality of medical care received by the Insured Person.

**Facilitation of Hospital Admittance Payments:** The Company's affiliate or authorized vendor will issue a financial guarantee (or wire funds) on behalf of Company up to five thousand dollars (US$5,000) to facilitate admittance to a foreign (non-US) medical facility.

**Relay of Insurance and Medical Information:** Upon an Insured Person's request and authorization, the Company's affiliate or authorized vendor will relay the Insured Person's insurance benefit information and/or medical records and information to a health care provider or treating physician, as appropriate and permissible, to help prevent delays or denials of medical care. The Company's affiliate or authorized vendor will also assist with hospital admission and discharge planning.

**Medication and Vaccine Transfers:** In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, the Company's affiliate or authorized vendor will coordinate the transfer of the medication or vaccine to Insured Persons upon the prescribing physician's authorization, if it is legally permissible.

**Updates to Family, Employer, and Home Physician:** Upon an Insured Person's approval, the Company's affiliate or authorized vendor will provide periodic case updates to appropriate individuals designated by the Insured Person in order to keep them informed.

**Hotel Arrangements:** The Company's affiliate or authorized vendor will assist Insured Persons with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care.

**Replacement of Corrective Lenses and Medical Devices:** The Company's affiliate or authorized vendor will assist with the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

**WORLDWIDE DESTINATION INTELLIGENCE**

**Destination Profiles:** When preparing for travel, an Insured Person can contact the Company's affiliate or authorized vendor to have a pre-trip destination report sent to the Insured Person. This report draws upon an intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. The global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

**TRAVEL ASSISTANCE SERVICES**

**Language Services:** The Company's affiliate or authorized vendor will provide immediate interpretation assistance to an Insured Person in a variety of languages in an emergency situation. If a requested interpretation is not available or the requested assistance is related to a non-emergency situation, the Company's affiliate or authorized vendor will provide the Insured Person with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter, will be subject to an additional fee.

**Message Transmittals:** Insured Persons may send and receive emergency messages toll-free, 24-hours a day, through the Company's affiliate or authorized vendor.

## HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

Assistance and Evacuation Services are available 24 hours a day, 7 days a week, 365 days a year.

To access services, please refer to the phone number on the back of the Insured Person's ID Card or access My Account at www.uhcsr.com/MyAccount and select My Benefits/Additional Benefits/UHC Global Emergency Services.

When calling the Emergency Response Center, the caller should be prepared to provide the following information:

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

If the condition is a medical emergency, the Insured Person should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center.

All medical expenses related to hospitalization and treatment costs incurred should be submitted to the Company for consideration at the address located in the "How to File a Claim for Injury and Sickness Benefits" section of the Certificate of Coverage and are subject to all Policy benefits, provisions, limitations, and exclusions.

# NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

## LANGUAGE ASSISTANCE PROGRAM

**We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.**

**English**
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

**Albanian**
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

**Amharic**
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይቀርባሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

**Arabic**
تتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم 1-866-260-2723.

**Armenian**
Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

**Bantu- Kirundi**
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

**Bisayan- Visayan (Cebuano)**
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

**Bengali- Bangala**
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723–তে কল করুন।

**Burmese**
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

**Cambodian- Mon-Khmer**
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

**Cherokee**
ᎦᏬᏂᏯᏍᏗ ᎤᎾᏓᏍᏚᏓᏗ ᎤᎾᏓᏇᎬᎢ ᏂᎾ ᎡᎦᏲᎯᏎᏍᏗ ᏂᏓᎬᎦᏫᏍ ᎠᏎᏍᎢ. ᏰᏳᎳ ᎠᏂ ᏫᏓᏔᏲᏍ 1-866-260-2723.

**Chinese**
您可以免費獲得語言援助服務。請致電 1-866-260-2723。

**Choctaw**
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

**Cushite- Oromo**
Tajaajilliwwan gargaarsa afaanii kanfaltii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-2723 bilbili.

**Dutch**
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

**French**
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

**French Creole- Haitian Creole**
Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

**German**
Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

**Greek**
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

**Gujarati**
ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

**Hawaiian**
Kōkua manuahi ma kāu ʻōlelo i kaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

**Hindi**
आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

**Hmong**
Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

**Ibo**
Enyemaka na-ahazi asụsụ, bụ n'efu, dịrị gị. Kpọọ 1-866-260-2723.

**Ilocano**
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

**Indonesian**
Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

**Italian**
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

**Japanese**
無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

**Karen**
[illegible] 1-866-260-2723 [illegible]

**Korean**
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

**Kru- Bassa**
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

**Kurdish Sorani**
خزمەتگوزاری یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

**Laotian**
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

**Marathi**
भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

**Marshallese**
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeļok wōņāān. Jouj im kallok 1-866-260-2723.

**Micronesian- Pohnpeian**
Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

**Navajo**
Saad bee áka'e'eyeed bee áka'nida'wo'ígíí t'áá jiik'eh bee nich'į' bee ná'ahoot'i'. T'áá shǫǫdí kohjį' 1-866-260-2723 hodíílnih.

**Nepali**
भाषा सहायता सेवाहरु निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

**Nilotic-Dinka**
Kâk ë kuny ajuëër ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn col 1-866-260-2723.

**Norwegian**
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

**Pennsylvania Dutch**
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

**Persian-Farsi**
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

**Polish**
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

**Portuguese**
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

**Punjabi**
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

**Romanian**
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

**Russian**
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

**Samoan- Fa'asamoa**
O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

**Serbo- Croatian**
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

**Somali**
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

**Spanish**
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

**Sudanic- Fulfulde**
E woodi walliinde dow wolde caahu ngam maada. Noodu 1-866-260-2723.

**Swahili**
Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

**Syriac- Assyrian**
ܚܕܡܬܘܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܫܟܚܢܝܬܐ، ܐܝܬܠܗܘܢ ܩܕܡܝܟ ܡܓܢܐܝܬ. ܡܨܐܬܘܢ ܩܪܝ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

**Tagalog**
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

**Telugu**
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

**Thai**
**มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข**
1-866-260-2733

**Tongan- Fakatonga**
'Oku 'i ai pē 'a e sēvesi ki he lea' ke tokoni kiate koe pea 'oku 'atā ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he 1-866-260-2723.

**Trukese (Chuukese)**
En mei tongeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

**Turkish**
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

**Ukrainian**
Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

**Urdu**
زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 1-866-260-2723 پر کال کریں۔

**Vietnamese**
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

**Yiddish**
שפּראַך הילף סערוויסעס זענען אויפֿנעמבאַר פֿאַר אײַך פֿרײַ פֿון אָפּצאָל. ביטע רופֿט 1-866-260-2723.

**Yoruba**
Isẹ́ iránlọ́wọ́ èdè ti ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.