2016–2017 Student Blanket Injury and Sickness Insurance Plan

Designed Especially for the Domestic Students of

Louisiana State University – Baton Rouge

Health care services may be provided to the Insured Person at a Network health care facility by facility-based Physicians who are not in the health plan. The Insured Person may be responsible for payment of all or part of the fees for those Out-of-Network services, in addition to applicable amounts due for Copayments, Coinsurance, Deductibles, and non-covered services. Specific information about the Preferred Provider and Out-of-Network facility-based Physicians can be found at the website address of the health plan or by calling the health plan’s customer service telephone number.

NOTICE: The Insured’s share of the payment for Covered Medical Expenses may be based on an agreement between the Company and the provider. Under certain circumstances, the agreement may allow the provider to bill the Insured for amounts up to the provider’s regular billed charge.
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14-BR-LA (PY16)
Privacy Policy

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

Eligibility

All Domestic undergraduate and graduate students registered for resident study and taking classes at LSU Baton Rouge are eligible to enroll in this insurance Plan.

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

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse and dependent children or grandchildren who meet the limits of a Dependent set forth in the Dependent definition.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 14, 2016. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 13, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$2,125</td>
<td>$844</td>
<td>$1,281</td>
<td>$408</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,125</td>
<td>$844</td>
<td>$1,281</td>
<td>$408</td>
</tr>
<tr>
<td>One Child</td>
<td>$2,125</td>
<td>$844</td>
<td>$1,281</td>
<td>$408</td>
</tr>
<tr>
<td>Two or More Children</td>
<td>$4,250</td>
<td>$1,688</td>
<td>$2,562</td>
<td>$816</td>
</tr>
<tr>
<td>Spouse + Two or More Children</td>
<td>$6,375</td>
<td>$2,532</td>
<td>$3,843</td>
<td>$1,224</td>
</tr>
</tbody>
</table>

How to Enroll

Eligible students who are interested in enrolling in the Student Health Insurance Plan should follow these instructions:

2. First Time Users will need to create a unique User account. Returning students can log in with their existing User Account information.
3. Once an account has been created, on the left toolbar, click ‘Student Direct Pay Enroll’.
4. Follow the instructions to complete the form and submit payment.
5. Enrollment in the plan will be processed once verification of your eligibility is approved by the University.

Students can enroll themselves through https://mylsu.apps.lsu.edu/group/mycampus/. Login to myLSU (“additional services” section under Registration Services tab) during class registration up to the 14th class day of that semester.
Student Health Center

Students MUST use the SHC as primary access to medical care, or to receive a referral for treatment outside of the SHC. See Student Health Center Requirements on page 20 for complete details.

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>Mental Health Counseling</th>
<th>Preventive &amp; Wellness Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary Care</td>
<td>• Emotional difficulties</td>
<td>• Screenings/Exams</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>• Substance abuse</td>
<td>• Immunizations/Vaccines</td>
</tr>
<tr>
<td>• Lab &amp; X-ray</td>
<td>• Marital and family distress</td>
<td>• Health Promotion Consults</td>
</tr>
<tr>
<td></td>
<td>• Academic concerns</td>
<td>• Health Workshops</td>
</tr>
</tbody>
</table>

Fall and Spring Semesters:

- Monday-Friday 8:00 a.m. to 5:00 p.m.
- *Saturday 9:00 a.m. to 12:30 a.m. Medical Clinic
- **Sunday 1:30 p.m. to 5:00 p.m.

*SHC is closed in the Fall on home game Saturdays
**Sunday hours are ONLY offered during the Fall when Home football games are on the previous Saturday

The Medical Clinic is closed on Wednesdays from 11:30 a.m. to 1:00 p.m. except for emergencies.

Summer and between semesters:

- Monday-Friday 8:00 a.m. to 4:15 p.m.

The Medical Clinic is closed on Wednesdays from 11:30 a.m. to 1:00 p.m. except for emergencies.

Location:

Corner of Infirmary Road and West Chimes Street across from the School of Music.

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.

Pre-Admission Notification

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

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

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

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

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

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

UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-844-288-4920 and/or by asking the provider when making an appointment for services.

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

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

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-844-288-4920 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

Continuity of Care; Termination of Provider Contracts

In the event a contract or agreement between the Company and health care provider is terminated, the health care provider shall notify the Company of any Insured who has begun a course of treatment by the provider before the effective date of the termination. Based on this notice from the health care provider, the Company shall notify the Insured of a termination of a health care provider from the Company’s network and the Insured’s right to continuity of care for Covered Medical Expenses that are covered or payable under the terms of the policy. The following provisions shall be applicable whether such termination is initiated by the Company or the health care provider:

1) In the event an Insured has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth week of pregnancy, the Insured shall be allowed to continue receiving Covered Medical Expenses, subject to the consent of the treating health care provider, through delivery and postpartum care related to the pregnancy and delivery while covered under this policy.

2) In the event an Insured has been diagnosed with a life-threatening Sickness, the Insured shall be allowed to continue receiving Covered Medical Expenses, subject to the consent of the treating health care provider, until the course of treatment is completed, not to exceed three months from the effective date of such termination while covered under this policy.
3) In the event a treating health care provider advises the Company of an Insured who meets the criteria above, the Company shall continue payment of the Company liability to the health care provider that was in effect prior to the termination of the contract or agreement with such health care provider. In addition, the contractual requirements for the health care provider to follow the Company’s utilization management and quality management policies and procedures shall remain in effect for the applicable period specified.

The provisions shall not apply when:

1) The reason for such termination is due to suspension, revocation, or applicable restriction of the health care provider’s license to practice in this state by the Louisiana State Board of Medical Examiners, or for another documented reason related to quality of care.

2) The Insured chooses to change health care providers.

3) The Insured moves out of the geographic service area of the health care provider or health insurance issuer.

4) The Insured requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

Schedule of Medical Expense Benefits

**METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 86.448 %**

**Injury and Sickness Benefits**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Overall Maximum Dollar Limit</strong></td>
<td></td>
</tr>
<tr>
<td>Deductible Preferred Providers</td>
<td>$250 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Deductible Preferred Providers</td>
<td>$750 (For all Insureds in a Family, Per Policy Year)</td>
</tr>
<tr>
<td>Deductible Out-of-Network</td>
<td>$500 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Deductible Out-of-Network</td>
<td>$1,500 (For all Insureds in a Family, Per Policy Year)</td>
</tr>
<tr>
<td>Coinsurance Preferred Provider</td>
<td>90% except as noted below</td>
</tr>
<tr>
<td>Coinsurance Out-of-Network</td>
<td>70% except as noted below</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Preferred Provider</td>
<td>$4,250 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Preferred Provider</td>
<td>$8,500 (For all Insureds in a Family, Per Policy Year)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Out-of-Network</td>
<td>$8,500 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Out-of-Network</td>
<td>$17,000 (For all Insureds in a Family, Per Policy Year)</td>
</tr>
</tbody>
</table>

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received within the Network from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. Except for a Medical Emergency, Covered Medical Expenses incurred at a Preferred Provider facility by an Out-of-Network provider will be paid at the Out-of-Network level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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

**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 benefits. Any applicable 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 per service Deductibles.

**Baton Rouge Student Health Center Benefits:** The Deductible and Copays will be waived when treatment is rendered at the LSU Student Health Center in Baton Rouge.
Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Please refer to the Medical Expense Benefits – Injury and Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

### Inpatient

<table>
<thead>
<tr>
<th></th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Expense</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Surgery</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
</tbody>
</table>

If two or more procedures or 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.

<table>
<thead>
<tr>
<th></th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Surgeon Fees</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Registered Nurse's Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician's Visits</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Pre-admission Testing</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
</tbody>
</table>

Payable within 14 working days prior to admission.

### Outpatient

<table>
<thead>
<tr>
<th></th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
</tbody>
</table>

If two or more procedures or 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.

<table>
<thead>
<tr>
<th></th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Surgery Miscellaneous</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Usual and Customary Charges</strong></td>
</tr>
</tbody>
</table>

Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.

<table>
<thead>
<tr>
<th></th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Surgeon Fees</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician's Visits</td>
<td>100% of Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td></td>
<td>$35 Copay per visit</td>
<td>$100 Deductible per visit</td>
</tr>
<tr>
<td></td>
<td>The Policy Deductible does not apply.</td>
<td>The Policy Deductible does not apply.</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>(All chiropractic care is payable under Physician's Visits.) Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Emergency Expenses</td>
<td>100% of Preferred Allowance</td>
<td>100% of Usual and Customary Charges</td>
</tr>
<tr>
<td></td>
<td>$100 Copay per visit</td>
<td>$100 Deductible per visit</td>
</tr>
<tr>
<td></td>
<td>The Policy Deductible does not apply.</td>
<td>The Policy Deductible does not apply.</td>
</tr>
<tr>
<td>Diagnostic X-ray Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Preferred Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Tests &amp; Procedures</strong></td>
<td>100% of Preferred Allowance $55 Copay per visit The Policy Deductible does not apply.</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Injections</strong></td>
<td>100% of Preferred Allowance $55 Copay per visit The Policy Deductible does not apply.</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>UnitedHealthcare Pharmacy (UHCP) $10 Copay per prescription for Tier 1 $40 Copay per prescription for Tier 2 $70 Copay per prescription for Tier 3 up to a 31 day supply per prescription</td>
<td>No Benefits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>See also Benefits for Prosthetic Devices and Prosthetic Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Consultant Physician Fees</strong></td>
<td>100% of Preferred Allowance $55 Copay per visit The Policy Deductible does not apply.</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Dental Treatment and Oral Surgery</strong></td>
<td>Paid as any other Sickness or Injury</td>
<td>Paid as any other Sickness or Injury</td>
</tr>
<tr>
<td><strong>Mental Illness Treatment</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Substance Use Disorder Treatment</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Complications of Pregnancy</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Elective Abortion</strong></td>
<td>No Benefits</td>
<td>No Benefits</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td>100% of Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a> for a complete list of services provided for specific age and risk groups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reconstructive Breast Surgery Following Mastectomy</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Facility</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Urgent Care Center</strong></td>
<td>Preferred Allowance</td>
<td>75% of Usual and Customary Charges $50 Deductible per visit The Policy Deductible does not apply.</td>
</tr>
<tr>
<td><strong>Hospital Outpatient Facility or Clinic</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Approved Clinical Trials</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Transplantation Services</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Pediatric Dental and Vision Services</strong></td>
<td>See Pediatric Dental and Vision Services for benefits</td>
<td></td>
</tr>
<tr>
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<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
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### UnitedHealthcare Pharmacy Benefits

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

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lower of the applicable Copayments or the Network Pharmacy’s Usual and Customary Fee for the Prescription Drug Product. Your Copayment/Coinsurance is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 1-855-828-7716 for the most up-to-date tier status.

- **$10** Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.
- **$40** Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.
- **$70** Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Mail order Prescription Drugs are available at 3 times the retail Copay up to a 90 day supply.

### Coverage Policies and Guidelines

The Company’s Prescription Drug List (“PDL”) Management Committee is authorized to make tier placement changes on its behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product’s acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

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<thead>
<tr>
<th>Other</th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td>Interpreter Expenses</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
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<tr>
<td>Medical Supplies</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
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<tr>
<td>Benefits are limited to a 31 day supply per purchase.</td>
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<tr>
<td>Sleep Disorders</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
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<td>Repatriation</td>
<td>Benefits provided by UnitedHealthcare Global</td>
<td>Benefits provided by UnitedHealthcare Global</td>
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<td>Medical Evacuation</td>
<td>Benefits provided by UnitedHealthcare Global</td>
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<td>Vision Care Expense</td>
<td>Preferred Allowance Examination $35 Copay per visit Materials $35 Copay per visit</td>
<td>Usual and Customary Charges Examination $35 Deductible per visit Materials $35 Deductible per visit</td>
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<tr>
<td>Applicable to Cover persons age 19 and older. Benefits are limited to: One pair of Lenses $25.00 maximum per Policy Year One frame $25.00 maximum per Policy Year Contact Lenses (in lieu of eyeglass lenses and frames) Fit, follow up &amp; materials $25 maximum per policy year Policy deductible does not apply.</td>
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</table>
The Company may periodically 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 occur 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 status of a Prescription Drug Product may change periodically 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 through the Internet or call Customer Service 1-855-828-7716 for the most up-to-date tier status.

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

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

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

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com and log in to your online account or call 1-855-828-7716.

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state law.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
10. 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.

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Definitions:

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

**Prescription Drug Cost** means the rate the Company has agreed to pay the Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at 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 assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

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

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. The Usual and Customary Fee includes a dispensing fee and any applicable sales tax.

**Insured Person’s Right to Request an Exclusion Exception for UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits**

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 1-866-948-8472. The Company will notify the Insured Person of the Company’s determination within 72 hours.

**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 1-866-948-8472. 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 1-866-948-8472 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.
Medical Expense Benefits – Injury and Sickness

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

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

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

Inpatient

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

2. Intensive Care.
   If provided in the Schedule of Benefits.

3. Hospital Miscellaneous Expenses.
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia.
   - Drugs (excluding take home drugs) or medicines.
   - Therapeutic services.
   - Supplies.

4. Routine Newborn Care.
   While Hospital Confined and routine nursery care provided immediately after birth.
   Benefits will be paid for an inpatient stay of at least:
   - 48 hours following a vaginal delivery.
   - 96 hours following a cesarean section delivery.

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

5. Surgery (Inpatient).
   Physician's fees for Inpatient surgery.

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

   Professional services administered in connection with Inpatient surgery.

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

   General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.
9. **Physician's Visits (Inpatient).**
   Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

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

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

**Outpatient**

11. **Surgery (Outpatient).**
    Physician's fees for outpatient surgery.

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

13. **Assistant Surgeon Fees (Outpatient).**
    Assistant Surgeon Fees in connection with outpatient surgery.

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

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

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

16. **Physiotherapy (Outpatient).**
    Includes but is not limited to the following rehabilitative services (including Habilitative Services):
    - Physical therapy.
    - Occupational therapy.
    - Cardiac rehabilitation therapy.
    - Manipulative treatment.
    - Speech therapy. 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, or cleft lip and cleft palate when prescribed by a Physician to improve or restore speech language deficits or swallowing deficits.

17. **Medical Emergency Expenses (Outpatient).**
    Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies and
    - The attending Physician's charges.
    - X-rays.
    - Laboratory procedures.

    All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. **Diagnostic X-ray Services (Outpatient).**
   Diagnostic X-rays are only those procedures identified in *Physicians' Current Procedural Terminology* (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.

19. **Radiation Therapy (Outpatient).**
   See Schedule of Benefits.

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

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

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

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

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

23. **Chemotherapy (Outpatient).**
   See Schedule of Benefits.

24. **Prescription Drugs (Outpatient).**
   See Schedule of Benefits.

**Other**

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

   Benefits include Medically Necessary transportation of:
   - A Newborn Infant to the nearest Hospital or neonatal special care unit for the treatment of a Sickness, Injury, Congenital Condition, and complications of a premature birth.
   - A temporarily medically disabled mother of a newborn Infant when accompanying the infant to the nearest Hospital or neonatal special care unit, upon recommendation by the mother’s attending Physician.

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.

See also Benefits for Prosthetic Devices and Prosthetic Services.

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

Dental treatment and oral surgery when services are performed by a Physician and limited to the following:
• Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
• Extraction of impacted teeth.
• Dental care and treatment including surgery and dental appliances required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof of or floor of mouth, and of Sound, Natural Teeth.
• Excision of exostoses or tori of the jaws and hard palate.
• Incision and drainage of abscess and treatment of cellulitis.
• Incision of accessory sinuses, salivary glands, and salivary ducts.
• Anesthesia for the above services or procedures when rendered by an oral surgeon.
• Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
• Anesthesia when rendered in a Hospital setting and for associated Hospital charges when an Insured’s mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders.
• Preparation for or follow-up to radiation therapy involving the mouth when specifically required for head and neck cancer patients.

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.

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.
• While confined to a Residential Treatment Center.

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.
• While confined to a Residential Treatment Center.

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.
Benefits will be paid for Medically Necessary:
- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.

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.

Benefits also include Private Duty Nursing services when both:
- The Insured’s Physician certifies that the services are Medically Necessary.
- The services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care professional.

For the purposes of this benefit, “Private Duty Nursing” means skilled nursing service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). Private duty nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private duty nursing does not include Custodial Care service.

37. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.
Hospice care includes:
- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.

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

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

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

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

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

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

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

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

“Approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

43. **Transplantation Services.**
Same as any other Sickness for organ, tissue, and bone marrow transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense. Benefits are limited to the following:
-Immunosuppressive drugs prescribed for transplant procedures.
- Solid human organ transplants as specified below:
  - Liver.
  - Heart.
  - Lung.
  - Kidney.
  - Pancreas.
  - Small bowel.
  - Other solid organ transplant procedures, which the Company determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.
- Tissue transplant procedures (autologous and Allogeneic) as specified below:
- Blood transfusions.
- Autologous parathyroid transplants.
- Corneal transplants.
- Bone and cartilage grafting.
- Skin grafting.
- Autologous islet cell transplants.
- Other tissue transplant procedures, which the Company determines have become standard, effective practices and have been determined to be effective procedures by peer reviewed literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case by case basis.

- Bone marrow transplants. Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.
- Acquisition Expenses. If a solid organ, tissue or bone marrow is obtained from a living donor for a covered transplant, the donor’s Covered Medical Expenses are covered as acquisition costs for the recipient.
- Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this policy to be primary.

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

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

44. **Cleft Lip and Cleft Palate.**
Same as any other Sickness for the treatment and correction of cleft lip and cleft palate, including secondary conditions and treatment attributable to the primary condition of cleft lip and cleft palate.

Benefits include, but are not limited to, the following:
- Oral and facial surgery, surgical management, and follow-up care.
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances.
- Orthodontic treatment and management.
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.
- Speech-language evaluation and therapy.
- Audiological assessments and amplification devices.
- Otolaryngology treatment and management.
- Psychological assessment and counseling.
- Genetic assessment and counseling for patient and parents.

45. **Genetic Testing.**
Benefits are limited to genetic testing when the results are specifically required for a medical treatment decision or when required by law.

46. **Hearing Aids.**
Hearing aids for Insured Persons age 17 and under 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. **Interpreter Expenses.**
Services of an interpreter/transliterator, other than a family member of the Insured, when such services are used by the Insured in connection with Covered Medical Expenses performed by a Physician.
48. **Medical Foods.**
Low Protein Food Products for the treatment of Inherited Metabolic Diseases.

For the purpose of this benefit:
- Low Protein Food Product means a food product that is especially formulated to have less than one gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low Protein Food Products shall not include a natural food that is naturally low in protein.
- Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry. Such diseases shall be limited to Phenylketonuria (PKU), Maple Syrup Urine Disease (MSUD), Methylmalonic Acidemia (MMA), Isovaleric Acidemia (IVA) Propionic Acidemia, Glutaric Acidemia, Urea Cycle Defects, and Tyrosinemia.

49. **Medical Supplies.**
Disposable medical equipment and supplies which have a primary medical purpose and meet all of the following criteria:
- Related to and necessary for the administration of Prescription Drugs, such as syringes and needles.
- 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.

50. **Sleep Disorders.**
Benefits are limited to Medically Necessary sleep studies and associated professional services when a sleep study is obtained in a facility accredited by the Joint Commission or the American Academy of Sleep Medicine.

**Mandated Benefits**

**BENEFITS FOR MAMMOGRAPHY**

Benefits will be provided for a mammogram subject to the following guidelines:

1) One baseline mammogram examination for a woman who is thirty-five through thirty-nine years of age.
2) One mammogram examination every one to two years, or more frequently if recommended by a Physician, for a woman who is forty through forty-nine years of age.
3) One mammogram every 12 months for a woman who is age fifty and over.

Mammography covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Mammography not covered by the Preventive Care Services benefit shall be covered under this benefit and shall not be subject to the policy Deductible, but shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the policy.

**BENEFITS FOR PAP SMEAR**

Benefits will be provided for an annual Pap Smear.

Pap Smears covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Pap Smears not covered by the Preventive Care Services benefit shall be covered under this benefit and shall not be subject to the policy Deductible, but shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the policy.

**BENEFITS FOR DETECTION OF PROSTATE CANCER**

Benefits will be provided for expenses incurred for Routine Prostate Preventive Care for the detection of prostate cancer, including digital rectal examinations and prostate-specific antigen testing as follows:

1) Annually for men over the age of fifty.
2) As Medically Necessary and appropriate for men over the age of forty.
“Routine Prostate Preventive Care” means a minimum of one routine annual visit, provided that a second visit shall be permitted based upon Medical Necessity and follow-up treatment within sixty days after either visit if related to a condition diagnosed or treated during the visits.

Routine Prostate Preventive Care covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Routine Prostate Preventive Care not covered by the Preventive Care Services benefit shall be covered under this benefit and shall not be subject to the policy Deductible, but shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the policy.

**BENEFITS FOR ROUTINE COLORECTAL CANCER SCREENING**

Benefits will be provided for Routine Colorectal Cancer Screening.

“Routine Colorectal Cancer Screening” shall mean a fecal immunochemical test for blood, flexible sigmoidoscopy, or colonoscopy provided in accordance with that most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced below:

1) Colonoscopy every ten years beginning at age 50 (or age 45 for African Americans).
2) Flexible sigmoidoscopy every five to ten years.
3) Annual FIT (fecal immunochemical test) for blood.

“Routine Colorectal Cancer Screening” shall not mean services otherwise excluded from coverage because they are deemed by the Company to be experimental or investigational.

Routine Colorectal Cancer Screening covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Routine Colorectal Cancer Screening not covered by the Preventive Care Services benefit shall be covered under this benefit and shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

**BENEFITS FOR OSTEOPOROSIS SCREENING**

Benefits will be provided for a Qualified Insured for Bone Mass Measurement for the diagnosis and treatment of osteoporosis.

For the purpose of this benefit, the following definitions shall apply:

1) "Bone mass measurement" means a radiologic or radioisotopic procedure or other scientifically proven technologies performed on an individual for the purpose of identifying bone mass or detecting bone loss.
2) "Qualified Insured" means: (a) An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment. (b) An individual receiving long term steroid therapy. (c) An individual being monitored to assess to response to or efficacy of approved osteoporosis drug therapies.

Bone Mass Measurement covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Bone Mass Measurement not covered by the Preventive Care Services benefit shall be covered under this benefit and shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

**BENEFITS FOR PROSTHETIC DEVICES AND PROSTHETIC SERVICES**

Benefits will be paid the same as any other Sickness for Medically Necessary Prosthetic Devices provided by an accredited facility and Prosthetic Services prescribed by a Physician and provided by an accredited facility. The Medical Necessity determination shall be based on information and recommendation from the treating Physician in consultation with the Insured, including the result of a functional limit test. The functional limit test shall consider, but not be limited to, the following factors:

1) The Insured’s past history, including prior use of Prosthetic Devices, if applicable.
2) The Insured’s current condition, including the status of the residual limb and the nature of other medical problems.
3) The Insured's desire to ambulate, with respect to lower limb prosthetic devices, or maximum upper limb function, with respect to upper limb prosthetic devices.

An "accredited facility" means any entity that is accredited by the American Board for Certification in Orthotics, Prosthetics, and Pedorthotics or by the Board for Orthotist/Prosthetist Certification and that provides prosthetic devices or prosthetic services.

“Prosthetic device” or “prosthesis” means an artificial limb designed to maximize function, stability, and safety of the patient. Prosthetic device or prosthesis also means an artificial medical device that is not surgically implanted and that is used to replace a missing limb. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

“Prosthetic services” means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. Prosthetic services shall also include any Medically Necessary clinical care.

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

**BENEFITS FOR THE TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER**

Benefits will be paid the same as any other Sickness for the diagnosis and treatment for attention deficit/hyperactivity disorder (ADHD) when rendered or prescribed by a Physician or other appropriate health care provider and received in any Physician's or other health care provider’s office, any licensed Hospital, or in any other licensed public or private facility, or portion thereof, including but not limited to clinics and mobile screening units.

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

**BENEFITS FOR THE DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS**

Benefits will be paid the same as any other Sickness for the Medically Necessary Diagnosis and Treatment of Autism Spectrum Disorders.

“Autism spectrum disorders” means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including but not limited to, Autistic Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

“Diagnosis of autism spectrum disorders” means medically necessary assessment, evaluations, or tests to diagnose whether an Insured has one of the autism spectrum disorders.

“Treatment of autism spectrum disorders” shall include the following care prescribed, provided, or ordered for an Insured diagnosed with one of the autism spectrum disorders by a Physician or psychologist:

1) Habilitative or rehabilitative care – professional, counseling, and guidance services and treatment program, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an Insured.
2) Pharmacy care – medications prescribed by a licensed Physician.
3) Psychiatric care – direct or consultative services provided by a licensed psychiatrist.
4) Psychological care - direct or consultative services provided by a licensed psychologist.
5) Therapeutic care – services provided by a licensed or certified speech therapist, occupational therapist, or physical therapist.

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

Benefits will be paid the same as any other Sickness for the treatment of lymphedema, including multilayer compression bandaging systems and custom or standard fit gradient compression garments.

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

**BENEFITS RELATED TO A SEXUALLY-ORIENTED CRIMINAL OFFENSE**

Benefits shall be provided for services rendered in conducting a forensic medical examination and shall include, but not be limited to, the following services directly related to the forensic examination:

1. Forensic examiner and Hospital or healthcare facility services, including integral forensic supplies.
2. Scope procedures, including but not limited to anoscopy and colposcopy.
3. Laboratory testing, including drug screening, urinalysis, pregnancy screening, syphilis screening, chlamydia culture, gonorrhea culture, blood test for HIV screening, hepatitis B and C screening, herpes culture, and any other sexually transmitted disease testing.
4. Any medication provided during the exam.

"Forensic medical examination" means an examination provided to a victim of a sexually-oriented criminal offense. The examination shall be conducted by a health care provider for the purpose of gathering and preserving evidence of a sexual assault for use in a court of law. A forensic medical examination shall include the following:

1. Examination of physical trauma.
2. Patient interview, including medical history, triage, and consultation.
3. Collection and evaluation of evidence, including but not limited to:
   a. Photographic documentation.
   b. Preservation and maintenance of chain of custody.
   c. Medical specimen collection.
   d. When necessary, an alcohol and drug facilitated sexual assault assessment and toxicology screening.

A claim related to a sexually-oriented criminal offense shall be submitted to the Company with the Insured victim's consent.

Upon receipt of a claim related to a sexually-oriented criminal offense, the Company shall:

1. Allow the Insured victim to designate any address to be used for the purposes of transmitting an explanation of benefits.
2. Allow the Insured victim to designate that no explanation of benefits be generated or transmitted.

The Company shall waive all applicable Deductible, Copayment, and Coinsurance provisions of the policy for any claim related to a sexually-oriented criminal offense.

**Coordination of Benefits Provision**

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

**Student Health Center (SHC) Referral Required**

**STUDENTS ONLY**

**OUTPATIENT SERVICES ONLY**

The student must use the services the Health Center first where outpatient treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A SHC referral for outside care is not necessary only under any of the following conditions:
1. Medical Emergency. The student must return to SHC for necessary follow-up care.
2. When the Student Health Center is closed.
3. When service is rendered at another facility during break or vacation periods.
4. Medical care received when the student is more than 25 miles from campus.
5. Medical care obtained when a student is no longer able to use the SHC due to a change in student status.
6. Maternity, obstetrical and gynecological care.

**Continuation Privilege**

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 12 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 6 months under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

Application must be made and premium must be paid directly to UnitedHealthcare Student Resources and be received within 14 days after the expiration date of your student coverage. For further information on the Continuation privilege, please contact UnitedHealthcare Student Resources.

**Definitions**

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

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

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

**BENEFICIARY** means a person designated by an Insured Person, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

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

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

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

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

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

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

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

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

DEPENDENT means the legal spouse 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.

Dependent shall also mean a grandchild until the age of 26 who is in the legal custody of and residing with the grandparent.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child:

1) Is incapable of self-sustaining employment by reason of intellectual or physical disability.
2) Became so incapable prior to the attainment of age twenty-six.
3) Is 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 after the two year period following the child's attainment of the limiting age.

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

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that:

1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means with respect to a Medical Emergency:

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

HABILITATIVE SERVICES means health care services that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy, and other services for people with disabilities.

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

A service that does not help the Insured person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service
by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

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

1. 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.

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

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

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

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

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

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

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

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

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

**MEDICAL NECESSITY/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.

No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement.

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

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

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth or date of discharge. 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 after birth or date of discharge. To continue the coverage the Insured must, within the 31 days after the child’s birth: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child’s birth.

In addition, an Insured Person shall be authorized to add a newborn child to this coverage at any time prior to the child’s birth to be effective upon the date of the child’s birth. Such coverage shall be subject to payment of the required additional premium, if any, for the child’s coverage.

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

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

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

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

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

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

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

RESIDENTIAL TREATMENT CENTER means a twenty-four (24) hour, non-acute care treatment setting for the active treatment of specific impairments of Mental Illness or Substance Use Disorder.
SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy’s Effective Date will be considered a sickness under this policy.

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

SOUND, NATURAL TEETH means natural teeth where the major portion of the individual tooth is present and includes those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound, natural teeth may have fillings or root canals but may not be carious, abscessed, or defective.

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

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

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

Exclusions and Limitations

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

1. Acupuncture.
4. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct a Congenital Condition existing at or from birth which significantly interferes with normal bodily function, such as cleft lip and cleft palate.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
5. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
6. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As described under Dental Treatment and Oral Surgery in the policy. This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
7. Elective Surgery or Elective Treatment.
8. Elective abortion.
9. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline, or chartered aircraft only while participating in a school sponsored intercollegiate sport.
10. Foot care for the following:
    - Flat foot conditions.
• Supportive devices for the foot.
• Subluxations of the foot.
• Fallen arches.
• Weak feet.
• Chronic foot strain.
• 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 for Insured Persons with diabetes.

11. Genetic testing, except as specifically provided in the policy.
12. Health spa or similar facilities. Strengthening programs.
15. Injury or Sickness for which benefits are paid or payable under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation.
16. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance except when due to the fault of a third party.
17. Injury sustained while:
   • Participating in any interscholastic, intercollegiate, or professional sport, contest or competition.
   • Traveling to or from such sport, contest or competition as a participant.
   • Participating in any practice or conditioning program for such sport, contest or competition.
18. Lipectomy.
19. Marital or family counseling.
20. Methadone maintenance treatment for Substance Use Disorders.
21. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
22. Prescription Drugs, services or supplies as follows:
   • Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
   • Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
   • Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
   • Products used for cosmetic purposes.
   • Drugs used to treat or cure baldness. Anabolic steroids used for body building.
   • Anorectics - drugs used for the purpose of weight control.
   • Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
   • Growth hormones, except for chronic renal insufficiency, AIDS wasting, Turners Syndrome, and growth hormone deficiency with abnormal provocative stimulation testing.
   • Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. Reproductive/Infertility services including but not limited to 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, except to diagnose or treat the underlying cause of the infertility.
   • Premarital examinations.
   • Impotence, organic or otherwise.
   • Reversal of sterilization procedures.
24. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.

This exclusion does not apply as follows:
• When due to a covered Injury or disease process.
• To benefits specifically provided in Pediatric Vision Services.
• To the initial fitting and one pair of eyeglasses or contact lenses required following cataract surgery.
26. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.

27. Preventive care services, except as specifically provided in the policy, including:
   - Routine physical examinations and routine testing.
   - Preventive testing or treatment.
   - Screening exams or testing in the absence of Injury or Sickness.

28. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.


31. Sleep disorders, except as specifically provided in the policy.

32. Speech therapy, except as specifically provided in the policy.

33. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.

34. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:
   - Motorcycle.
   - Recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle, four-wheeled all terrain vehicle (ATV), jet ski, ski cycle, or snowmobile.

35. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

36. 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).

37. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.

UnitedHealthcare Global: Global Emergency Services

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

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

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

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to $5,000.00 payment (when included with your enrollment in an UnitedHealthcare StudentResources health insurance policy)
- Facilitation of Hospital Admission Payments (when Global Emergency Services is purchased as a stand-alone supplement)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
• Replacement of Lost or Stolen Travel Documents
• Repatriation of Mortal Remains
• Worldwide Destination Intelligence Destination Profiles
• Legal Referral
• Transfer of Funds
• Message Transmittals
• Translation Services
• Security and Political Evacuation Services
• Natural Disaster Evacuation Services

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

To access services please call:
1-(800) 527-0218 Toll-free within the United States
1-(410) 453-6330 Collect outside the United States

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

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

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

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

Online Access to Account Information

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

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

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

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to My Account as described above and select UnitedHealth Allies Plan to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.
Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service for treatment or referral, or when not in school, to their Physician or Hospital.

2. Mail to the address below all medical and hospital bills along with the patient’s name and insured student’s name, address, SR ID number (insured’s insurance company ID number) and name of the 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.

Submit the above information to the Company by mail:

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

Pediatric Dental Services Benefits

Benefits are provided for Covered Dental Services for Insured Persons under the age of 19. Benefits terminate on the earlier of:
1) 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.

Covered Dental Services shall include all federally required pediatric dental benefits outlined under the 2012 FEDVIP Dental Plan. The FEDVIP Dental Plan can be found at: http://archive.opm.gov/insure/health/planinfo/2012/brochures/MetLife.pdf.

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 1-877-816-3596 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured’s ID card.

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

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

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

Pre-Treatment Estimate

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

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

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

Pre-Authorization

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

Section 2: Benefits for Pediatric Dental Services

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

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

Dental Services Deductible

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

Out-of-Pocket Maximum

Any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this benefit applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits.

Benefits

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

#### Network Benefits
Benefits are shown as a percentage of Eligible Dental Expenses.

#### Non-Network Benefits
Benefits are shown as a percentage of Eligible Dental Expenses.

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Intraoral Periapical First Film, Intraoral Periapical Each Additional Film Intraoral Occlusal Film</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Cephalometric X-ray Oral / Facial Photographic Images Diagnostic Models</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Periodic / Comprehensive Oral Evaluation (Checkup Exam) Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited Oral Evaluation (Problem Focused) Limited to 1 time per 6 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Comprehensive Periodontal Evaluation Limited to 1 time per 6 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Space Maintainers (Spacers)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Minor Restorative Services, Endodontics, Periodontics and Oral Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Protective Restoration Pin Retention (Per Tooth) in addition to Restoration</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
| Re-Cementation  
  • Space Maintainer - Limited to Children under Age 19  
  • Inlay  
  • Crown | 50% | 50% |
| Endodontics (Root Canal Therapy) | 50% | 50% |
| Periodontal Surgery (Gum Surgery) | 50% | 50% |
| Gingivectomy / Gingivoplasty  
  • One to Three Teeth  
  • Four or More Teeth – Limited to 1 time per 36 months | 50% | 50% |
| Gingival Flap Procedure – Four or more teeth Limited to 1 time per 36 months | 50% | 50% |
| Clinical Crown Lengthening – Hard Tissue | 50% | 50% |
| Osseous Surgery – Including Flap Entry and Closure  
  Four or more contiguous teeth or bounded teeth spaces | 50% | 50% |
<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 1 time per 36 month.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pedical Soft Tissue Graft Procedure</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Free Soft Tissue Graft Procedure (including donor sit surgery)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Full Mouth Debridement</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per Lifetime</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaling and Root Planing (Deep Cleanings)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per quadrant per 24 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Periodontal Maintenance (Gum Maintenance)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Therapeutic Pulpotomy</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial Pulpotomy for Apexogenesis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Tissue Conditioning (Maxillary and Mandibular)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Fixed Partial Denture</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Extractions (Simple tooth removal)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Oral Surgery, including Surgical Extraction</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Deep Sedation / General Anesthesia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Intravenous Conscious Sedation / Analgesia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Therapeutic Drug Injection</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Consultation (Provided by Dentist / Physician other than practitioner providing treatment)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Treatment of Post-Surgical Complications</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Adjuvntive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Services (including Dental Emergency treatment)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Covered as a separate benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guards limited to 1 guard every 12 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Major Restorative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Detailed and Extensive Oral Evaluation – Problem Focused</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns (Partial to Full Crowns)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Fixed Prosthetics (Bridges)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Retainer</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Cast metal for resin bonded fixed prosthesis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Porcelain /ceramic for resin binded fixed prosthesis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Core buildup for retainer, including pins</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removable Prosthetics (Full or partial dentures)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months. No additional allowances for precision or semi-precision attachments.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Relining and Rebasing Dentures</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Core Buildup, Including pins Limited to 1 time per tooth per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Prefabricated Post and Core, in addition to Crown Limited to 1 time per tooth per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Crown Repair</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Placement Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Implant Supported Prosthetics Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Repair Implant Abutment by Support Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>MEDICALLY NECESSARY ORTHODONTICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon’s syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company’s dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Pre-Orthodontic Treatment Visit Periodic Orthodontic Treatment Visit</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited Orthodontic Treatment  • Primary dentition  • Transitional dentition  • Adolescent dentition Interceptive Orthodontic Treatment  • Primary dentition  • Transitional dentition Comprehensive Orthodontic Treatment  • Transitional dentition  • Adolescent dentition</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Appliance Therapy  • Removable  • Fixed</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
### Benefit Description and Limitations

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Retention</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>Removal of appliances, construction, and placement of retainer</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person’s Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person’s family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction, except for cleft lip/palate.
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 a non-Network provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

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

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

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

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

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

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

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-877-816-3596. This number is also listed on the Insured’s Dental ID Card.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

Covered Dental Service – a Dental Service or Dental Procedure for which benefits are provided under the policy.

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

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

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to the Insured Person while the policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.
Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the policy is in effect, are determined as stated below:

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

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

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

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

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

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

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

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

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

Pediatric Vision Care Services Benefits

Benefits are provided for Vision Care Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) 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 Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-800-839-3242. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.
When Vision Care Services are obtained from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then seek reimbursement from the Company as described under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

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

**Network Benefits**

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

**Non-Network Benefits**

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

**Out-of-Pocket Maximum**

Any amount the Insured Person pays in Coinsurance for Vision Care Services 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 applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits.

**Policy Deductible**

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

**Benefit Description**

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

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

**Frequency of Service Limits**

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

**Routine Vision Examination**

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

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

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

**Eyeglass Lenses** - Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

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

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

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

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

**Necessary Contact Lenses** - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:
- Keratoconus.
- Pathological myopia.
- Anisometropia.
- Aniseikonia.
- Aniridia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal disorders.
- Post-traumatic disorders.

**Low Vision**
Benefits are available to an Insured Person who has 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.

This benefit includes:

- **Low Vision Testing**: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- **Low Vision Therapy**: Subsequent low vision therapy if prescribed.
- **Low Vision Aids**: Prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes.
## Schedule of Benefits

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Vision Examination</td>
<td>Once per year.</td>
<td>100% after a Copayment of $20.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Eyeglass Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Bifocal</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Trifocal</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Lenticular</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Lens Extras</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polycarbonate</td>
<td></td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Standard Scratch-resistant coating</td>
<td></td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Each of the following is a separate charge shown under columns Network and Non-Network Benefits:</td>
<td></td>
<td>20% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>Blended segment lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate vision lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Progressives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Progressives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photochromic Glass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plastic Photosensitive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polarized</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hi-Index</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Anti-Reflective Coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultra Anti-Reflective Coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV Coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eyeglass Frames</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost up to $130.</td>
<td></td>
<td>100%</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost of $130 - $160.</td>
<td></td>
<td>100% after a Copayment of $15.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost of $160 - $200.</td>
<td></td>
<td>100% after a Copayment of $30.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost of $200 - $250.</td>
<td></td>
<td>100% after a Copayment of $50.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost greater than $250.</td>
<td></td>
<td>60%</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Contact Lens Fitting and Evaluation</strong></td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Contact Lens Selection</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Necessary Contact Lenses</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Low Vision Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note that benefits for these services will be paid as reimbursements. When</td>
<td></td>
<td>Once every 24 months</td>
<td></td>
</tr>
</tbody>
</table>
### Vision Care Service

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>obtaining these Vision Services,</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>the Insured will be required to</td>
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<td>pay all billed charges at the time</td>
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<tr>
<td>of service. The Insured may then</td>
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<tr>
<td>obtain reimbursement from the</td>
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</tr>
<tr>
<td>Company. Reimbursement will</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>be limited to the amounts stated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low Vision Testing</td>
<td></td>
<td>100% of the billed charge.</td>
<td>75% of the billed charge</td>
</tr>
<tr>
<td>• Low Vision Therapy</td>
<td></td>
<td>100% of the billed charge.</td>
<td>75% of the billed charge</td>
</tr>
<tr>
<td>• Low Vision Aids</td>
<td></td>
<td>100% of the billed charge.</td>
<td>75% of the billed charge</td>
</tr>
</tbody>
</table>

### Section 2: Pediatric Vision Exclusions

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

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

### Section 3: Claims for Pediatric Vision Care Services

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

### Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

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

By Facsimile (fax):
- 1-248-733-6060

### Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision Services, the Insured Person must provide all of the following information at the address specified below:

- Insured Person’s itemized receipts.
- Insured Person’s name.
- Insured Person’s identification number.
- Insured Person’s date of birth.
Submit the above information to the Company:

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

By Facsimile (fax):
1-248-733-6060

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

Section 4: Defined Terms for Pediatric Vision Care Services
The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

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 will be made whole or fully compensated before the Company subrogates. 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. The Company will pay its portion of the Insured’s attorneys’ fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this policy pursuant to this provision.

Notice of Appeal Rights

RESOLUTION OF GRIEVANCE NOTICE
INTERNAL APPEAL PROCESS AND EXTERNAL INDEPENDENT REVIEW PROCESS
RELATED TO HEALTH CARE SERVICES

DEFINITIONS
For the purpose of this Notice, 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.

INTERNAL APPEAL PROCESS

Within 180 days 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.

Within 3 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;
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 60 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 received, 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; and
6. The Insured Person’s right to bring a civil action in a court of competent jurisdiction.
7. Notice of the Insured Person’s right to contact the commissioner’s office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner’s office.

** Expedited Internal Review (EIR) of an Adverse Determination **

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 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 the 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. If the notice is provided orally, then the Company shall provide a written or electronic version of the notice within 3 days following the oral notice.

EXTERNAL INDEPENDENT REVIEW

An Insured Person or Authorized Representative may submit a request for an External Independent Review when the service 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 Procedure 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 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Company.

I. Standard External Review (SER) Process

1. Within 5 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 5 business days after completion of the preliminary review, the Company shall notify the Commissioner, 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 Commissioner.

c. If the request is not eligible, the Insured Person or the Authorized Representative may submit a written request for reconsideration to the Commissioner. The Commissioner may determine that a request is eligible for external review and require that it be referred for external review.

d. If the Commissioner determines that a request is eligible for external review, the Commissioner shall notify the Company and the Insured Person or the Authorized Representative within 5 business days.

3. After determining that a request is eligible for SER or after receiving notice from the Commissioner that a request is eligible for SER, the Company shall, within 1 business day, input a request for an assignment of an Independent Review Organization (IRO) through the Department of Insurance website. Upon notification through the website, the Commissioner shall:
   a. Assign an Independent Review Organization (IRO) from the Commissioner’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 5 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 5 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 1 business day, advise the Commissioner, 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 1 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 its decision, the Company shall provide written notification within 1 business day to the Commissioner, 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 Commissioner, 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.

II. Expedited External Review (EER) Process

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Company at the time the Insured Person receives:
   a. An Adverse Determination if:
      (i) the Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      (ii) 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:
      (i) 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
      (ii) 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.

2. Upon receipt of an EER request, the Company shall send a copy of the request to the Commissioner within 1 business day.

3. 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 sections II. 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.

4. Immediately after completion of the review, the Company shall notify the Commissioner, 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 Commissioner.
   c. If the request is not eligible, the Insured Person or the Authorized Representative may submit a written request for reconsideration to the Commissioner. The Commissioner may determine that a request is eligible for external review and require that it be referred for external review.
   d. If the Commissioner determines that a request is eligible for external review, the Commissioner shall immediately notify the Company and the Insured Person or the Authorized Representative.

5. After determining that a request is eligible for EER or after receiving notice from the Commissioner that a request is eligible for EER, the Company shall, within 1 business day, input a request for an assignment of an Independent Review Organization (IRO) through the Department of Insurance website.

6. Upon notification through the website, the Commissioner shall immediately assign an IRO from the Commissioner'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.

7. 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.

8. 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 Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.

9. 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.

III. Experimental or Investigational Treatment External Review (EIER) Process

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for an Experimental or Investigational Treatment External Review (EIER) with the Company.

2. Within 5 business days after receiving the EIER 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 recommended, requested or provided;
   b. the recommended or requested health care services or treatment:
      (i) is a Covered Medical Expense under the Insured Person’s Policy except for the Company’s determination that the service or treatment is experimental or investigational for a particular medical condition; and
      (ii) is not explicitly listed as an Exclusion or Limitation under the Insured Person’s Policy;
c. the Insured Person's treating Physician has certified that one of the following situations is applicable:
   (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
   (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
   (iii) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;

d. the Insured Person's treating Physician:
   (i) has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
   (ii) who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;

e. the Insured Person has exhausted the Company's Internal Appeal Process; and

f. the Insured Person has provided all the information and forms necessary to process the request.

3. Within 5 business days after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a EIER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Company 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 Commissioner.

   c. If the request is not eligible, the Insured Person or the Authorized Representative may submit a written request for reconsideration to the Commissioner. The Commissioner may determine that a request is eligible for external review and require that it be referred for external review.

   d. If the Commissioner determines that a request is eligible for external review, the Commissioner shall notify the Company and the Insured Person or the Authorized Representative within 5 business days.

4. After determining that a request is eligible for EIER or after receiving notice from the Commissioner that a request is eligible for EIER, the Company shall, within 1 business day, input a request for an assignment of an IRO through the Department of Insurance website.

5. Upon notification through the website, the Commissioner shall:
   a. Assign an IRO from the Commissioner'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 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

6. a. The Company shall, within 5 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 EIER.

   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 immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.

7. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.

8. 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 1 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 EIER.
   b. The EIER 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 EIER.
   c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EIER.
9. After completion of the IRO’s review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment 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 except to the extent the Insured Person has other remedies available under applicable federal or state law. An Insured Person or an Authorized Representative may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Insured Person has already received an External Review decision.

Where to Send External Review Requests

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

- Claims Appeals
- UnitedHealthcare StudentResources
- PO Box 809025
- Dallas, TX 75380-9025
- 1-888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service at 1-866-948-8472 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. The State of Louisiana Department of Insurance is available to assist insurance consumers with insurance-related problems and questions. You may inquire in writing at:

- Louisiana Department of Insurance
- 1702 North Third Street
- Baton Rouge, LA 70802
- 1-(800) 259-5300
- 1-(225) 342-5900
- Website: www.ldi.state.la.us
The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Submit all Claims or Inquiries to:
UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, Texas 75380-9025
1-866-948-8472
gkclaims@uhcsr.com

QUESTIONS? NEED MORE INFORMATION?
For general information on benefits, eligibility and enrollment, ID Cards, please contact:
Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
1-844-288-4920
1-617-769-1219
www.gallaghestudent.com/LSU-BatonRouge

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

This Certificate is based on Policy # 2016-201720-1.