2014-2015

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

UNIVERSITY AT ALBANY
State University of New York

Limited Benefit Plan. Please Read Carefully.

Limited benefits health insurance. The insurance evidenced by this certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State Insurance Department.

UnitedHealthcare®

14-BR-NY

31-201212-1

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or visiting us at www.uhcsr.com/albany.

Eligibility

All full-time (12 credits or more) registered Undergraduate students are required to purchase this insurance Plan unless proof of comparable coverage is provided and a waiver is submitted by the advertised deadline.

Graduate students 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 under 26 years of age.

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 20, 2014. 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 19, 2015. 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.

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 14 days after the coverage expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

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

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

Premium Rates

Rates	Annual 8/20/14 - 8/19/15	Fall 8/20/14 - 1/18/15	Spring/Summer 1/19/15 - 8/19/15	Summer 5/20/15 - 8/19/15
Student	1,150.00	479.00	671.00	290.00
Spouse	5,762.00	2,400.00	3,362.00	1,452.00
Each Child	4,188.00	1,744.00	2,444.00	1,056.00

How to Enroll

All full-time undergraduate students taking 12 or more credit hours are automatically enrolled in this insurance Plan unless a waiver was submitted by the advertised deadline. If you are currently covered under a health insurance plan, you may opt out of the plan UAlbany:

Deadline to waive coverage - October 14, 2014

Students who wish to purchase Dependent coverage must enroll directly with UnitedHealthcare **Student**Resources either online at www.uhcsr.com/albany or by mailing an enrollment form with premium payment to:

UnitedHealthcare **Student**Resources
PO Box 809026
Dallas, TX 75380-9026

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.

However, if an Insured is pregnant on the Termination Date and the conception occurred while covered under this policy, Covered Medical Expenses for such pregnancy will continue to be paid through the term of the pregnancy.

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 Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

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

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

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities. Call 1-800-767-0700 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

Schedule of Medical Expense Benefits

Metallic Level: GOLD

Injury and Sickness Benefits

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

Deductible Preferred Providers	$100 (For Each Injury or Sickness)
Deductible Out-of-Network	$250 (For Each Injury or Sickness)
Coinsurance Preferred Providers	80% except as noted below
Coinsurance Out-of-Network	60% except as noted below
Out-of-Pocket Maximum Preferred Providers	$6,350 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Providers	$12,700 (For all Insureds in a Family, Per Policy Year)

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

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

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 Preferred Providers: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses 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.

Student Health Center Benefits (Students Only): The Preferred Provider Deductible will be reduced to $50 per Injury or Sickness when services or treatment is received at the University Student Health Center, or when referred to a Preferred Provider by the Student Health Center Physician. If the University Health Center is closed, the Deductible will only be reduced to $50 if treatment is a result of an Emergency Medical Condition. Dependents are not eligible to be seen at the University Health Center.

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

Inpatient	Preferred Provider	Out-of-Network
Room and Board Expense (The Copay/per visit Deductible is in addition to the Policy Deductible.)	Preferred Allowance $100 Copay per day $300 maximum Copay per Hospital Confinement	Usual and Customary Charges $100 Deductible per day $300 maximum Deductible per Hospital Confinement
Intensive Care (The Copay/per visit Deductible is in addition to the Policy Deductible.)	Preferred Allowance $100 Copay per day $300 maximum Copay per Hospital Confinement	Usual and Customary Charges $100 Deductible per day $300 maximum Deductible per Hospital Confinement
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care See Benefits for Maternity Expenses	Paid as any other Sickness	Paid as any other Sickness
Surgery 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.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	No Benefits	No Benefits
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing Payable within 3 working days prior to admission.	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
Surgery 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.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance $100 Copay per visit	Usual and Customary Charges $100 Deductible per visit
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits Benefits include chiropractic care.	Preferred Allowance	Usual and Customary Charges
Physiotherapy All chiropractic care is payable under Physicians Visits. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. (No referral required)	Preferred Allowance $100 Copay per visit	80% of Usual and Customary Charges $100 Deductible per visit
Diagnostic X-Ray Services	Preferred Allowance $50 Copay per visit	Usual and Customary Charges $50 Deductible per visit
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance $25 Copay per visit	Usual and Customary Charges $25 Deductible per visit
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Prescription Drugs Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply. (For Students only: In order to receive the first $100 for the Fall and Spring semesters in covered prescription expenses paid at 100%, with the exception of Copays, students must have prescriptions dispensed by the University Health Center. Once covered expenses exceed the cap each semester, additional covered prescription expenses will be payable under this plan description.)	UnitedHealthcare Pharmacy (UHCP) $25 Copay per prescription for Tier 1 $40 Copay per prescription for Tier 2 $75 Copay per prescription for Tier 3 up to a 31 day supply per prescription If a retail UnitedHealthcare Pharmacy offers to accept a price that is comparable to that of mail order pharmacy, then up to a consecutive 90 day supply of a Prescription Drug Product at 2.5 times the Copay that applies to a 31 day supply per prescription.	No Benefits

Other	Preferred Provider	Out-of-Network
Ambulance Services	100% of Preferred Allowance	100% of Usual and Customary Charges
Durable Medical Equipment	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees	Preferred Allowance	Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth and for Congenital Conditions only.	Preferred Allowance	Usual and Customary Charges
Mental Illness Treatment See Benefits for Mental Illness Treatment, Benefits for Biologically Based Mental Illness, and Benefits for Children with Serious Emotional Disturbances	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment See Benefits for Chemical Dependence (Alcoholism/Drug Abuse)	Paid as any other Sickness	Paid as any other Sickness
Maternity See Benefits for Maternity Expenses	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion ($350 maximum Per Policy Year) (For pregnancy having its inception during the term insured.)	Preferred Allowance	Usual and Customary Charges
Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.	100% of Preferred Allowance	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Breast Cancer Treatment	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes Expenses	Paid as any other Sickness	Paid as any other Sickness
Home Health Care (40 visits maximum (Per Policy Year))	Preferred Allowance	Usual and Customary Charges
Hospice Care	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	Preferred Allowance	Usual and Customary Charges
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids	Preferred Allowance	Usual and Customary Charges
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges
Ostomy Supplies	Preferred Allowance	Usual and Customary Charges
Wigs	Preferred Allowance	Usual and Customary Charges

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.

You are responsible for paying the applicable Copayments. Your Copayment 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.

$25 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.

$75 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 2.5 times the retail Copay up to a 90 day supply.

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

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

Note: In the event of a State of Emergency, the Company may allow a temporary exception to this Designated Pharmacy requirement, as directed by the State Department of Financial Services.

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.

<u>Additional Exclusions:</u>
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 mandate.

Definitions:

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

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

Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Note: In the event of a State of Emergency, the Company may allow a temporary exception to this Designated Pharmacy requirement, as directed by the State Department of Financial Services.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

1) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified as appropriate for the proposed use in any of the following established reference compendia:
   (a) the American Hospital Formulary Service-Drug Information;
   (b) the national Comprehensive Cancer Networks Drugs and Biologics Compendium;
   (c) Thompson Micromedex Drugdex;
   (d) Elsevier Gold Standard's Clinical Pharmacology; or
   (e) other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS) or recommended by review article or editorial comment in a major peer reviewed professional journal.
2) Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

1) Clinical trials for which benefits are specifically provided for in the policy.
2) If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

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

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

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

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

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

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

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

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

Prescription Drug 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.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service at 1-855-828-7716.

Prescription Drug List Management Committee means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

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 at 1-855-828-7716.

Therapeutically Equivalent means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

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.**
   See Benefits for Maternity Expenses.

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

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

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

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

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

9. **Physician's Visits (Inpatient).**
   Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

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

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

Outpatient

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

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

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

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

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

Benefits include the following services when performed in the Physician's office.
- Chiropractic care in connection with the detection or correction, by manual or mechanical means, of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column.

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.

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:

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. Benefits will not be denied for refills of prescription eye drop medications based upon any restriction on the number of days before a refill may be obtained; provided that such refill shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The pharmacist may contact the prescribing Physician to verify the prescription.

Other

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

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

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

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

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

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:
- Injury to Sound, Natural Teeth.
- Congenital Conditions.

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.**
See Benefits for Mental Illness Treatment, Benefits for Biologically Based Mental Illness, and Benefits for Children with Serious Emotional Disturbances.

30. **Substance Use Disorder Treatment.**
See Benefits for Chemical Dependence (Alcoholism/Drug Abuse).

31. **Maternity.**
Same as any other Sickness. See Benefits for Maternity Expenses.

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

33. **Preventive Care Services.**
Includes only those 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 or partial mastectomy. See Benefits for Breast Cancer Treatment.

35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes Expense.

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

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

37. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less.

All hospice care must be received from a licensed hospice agency.

Hospice care includes:
- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members either before or after the Insured Person's death.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

45. **Medical Supplies**.
- Medical supplies must meet all of the following criteria:
- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

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

46. **Ostomy Supplies**.
- Benefits for ostomy supplies are limited to the following supplies:
- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

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

47. **Wigs**.
- Wigs and other scalp hair prosthesis as a result of hair loss:
- Due to a covered Injury or Sickness.
- As a side effect of the treatment of a Sickness.

Benefits are limited to one wig per Policy Year. Wigs made from human hair are not covered unless the Insured Person is allergic to all synthetic wig materials.

Maternity Testing

This policy does not cover all routine, preventive, or screening examinations or testing. The policy will cover those Maternity tests as required by the *Health Resources and Services Administration's* comprehensive guidelines for women's preventive care and screening as updated, when received from a Preferred Provider with no cost share as referenced in the Preventive Care Services Benefits listed in the Schedule.

The following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met. (Additional Maternity testing may be allowed if Medical Necessity is established based on medical records.)

Initial screening at first visit:

- Pregnancy test: urine human chorionic gonatropin (HCG)
- Asymptomatic bacteriuria: urine culture
- Blood type and Rh antibody
- Rubella
- Pregnancy-associated plasma protein-A (PAPPA) **(first trimester only)**
- Free beta human chorionic gonadotrophin (hCG) **(first trimester only)**
- Hepatitis B: HBsAg
- Pap smear
- Gonorrhea: Gc culture
- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test
- Cystic fibrosis screening

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

- Ultrasound (anatomy scan)
- Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a

Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS), non-invasive fetal aneuploidy DNA testing

Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered, except folic acid supplements with a written prescription. For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

Mandated Benefits

Benefits for Maternity Expenses

Benefits will be paid the same as any other Sickness for pregnancy. Benefits will include coverage for an Insured mother and newborn confined to a Hospital as a resident inpatient for childbirth, but, in no event, will benefits be less than:

1. 48 hours after a non-cesarean delivery.
2. 96 hours after a cesarean section.

Benefits for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. The Company will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Physician.

Benefits will be paid for:

1. Parent education.
2. Assistance and training in breast or bottle feeding.
3. The performance of any necessary maternal and newborn clinical assessments.

In the event the mother chooses an earlier discharge, at least one home visit will be available to the mother, and not subject to any Deductibles, Coinsurance, or Copayments.

The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) shall be conducted within 24 hours following the later of:

1. Discharge from the Hospital.
2. The mother's request.

Except for the one home visit after early discharge, all benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

If the Insured Person's insurance should expire, the policy will pay under this benefit providing conception occurred while the policy was in force.

Benefits for Diabetes Expense

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the treatment of diabetes. Such equipment and supplies must be recommended or prescribed by a Physician. Covered Medical Expenses includes but are not limited to the following equipment and supplies:

1. Lancets and automatic lancing devices.
2. Glucose test strips.
3. Blood glucose monitors.
4. Blood glucose monitors for the visually impaired.
5. Control solutions used in blood glucose monitors.
6. Diabetes data management systems for management of blood glucose.
7. Urine testing products for glucose and ketones.
8. Oral and injectable anti-diabetic agents used to reduce blood sugar levels.
9. Alcohol swabs, skin prep wipes and IV prep (for cleaning skin).
10. Syringes.
11. Injection aids including insulin drawing up devices for the visually impaired.
12. Cartridges for the visually impaired.
13. Disposable injectable insulin cartridges and pen cartridges.
14. Other disposable injectable medication cartridges and pen needles used for diabetes therapies.
15. All insulin preparations.
16. Insulin pumps and equipment for the use of the pump (e.g. batteries, semi-permeable transparent dressings, insertion devices, insulin infusion sets, reservoirs, cartridges, clips, skin adhesive and skin adhesive remover, tools specific to prescribed pump).
17. Oral agents for treating hypoglycemia such as glucose tablets and gels.
18. Glucagon emergency kits.

Benefits will also be paid for Medically Necessary diabetes self-management education and education relating to diet. Such education may be provided by a Physician or the Physician's staff as a part of an office visit. Such education when provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral by a Physician may be provided in a group setting. When Medically Necessary, self-management education and diet education shall also include home visits.

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

Benefits for Treatment of Chemical Dependence
(Alcoholism and Drug Abuse)

Benefits will be paid the same as any other Sickness for treatment of Chemical Dependence and Chemical Abuse.

Outpatient benefits include up to 20 outpatient visits per Policy Year for family members.

Benefits will be limited to facilities in New York state certified by the office of alcoholism and substance abuse services or licensed by such office as outpatient clinic or medically supervised ambulatory substance abuse programs and in other states to those which are accredited by the joint commission on accreditation of hospitals as alcoholism or chemical dependence treatment programs.

"Chemical abuse" means alcohol and substance abuse.

"Chemical dependence" means alcoholism and substance dependence.

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

Benefits for Cervical Cytological Screening and Mammograms

Benefits will be paid the same as any other Sickness for cervical cytology screening and mammograms.

1. Benefits will be paid for an annual cervical cytology screening for women (18) eighteen years of age and older. This benefit shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.
2. Benefits will be paid for mammograms as follows:
   a Upon a Physician's recommendation, Insureds at any age who are at risk for breast cancer or who have a first degree relative with a prior history of breast cancer.

   b A single base line mammogram for Insureds age 35 but less than 40.
   c A mammogram every year for Insureds age 40 and older.

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

Benefits for Breast Cancer Treatment

Benefits will be paid the same as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured for a lymph node dissection, a lumpectomy, mastectomy, or partial mastectomy for the treatment of breast cancer.

Breast reconstructive surgery after a mastectomy or partial mastectomy will also be paid as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured.

Benefits will be paid for:

1. All stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and any physical complications of all stages of mastectomy, including lymphedemas.

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

Benefits for Second Medical Opinion for Diagnosis of Cancer

Benefits will be paid the same as any other Sickness for a second medical opinion by an appropriate Physician, including but not limited to a Physician affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

Benefits will be paid at the Preferred Provider level of benefits for a second medical opinion by a non-participating Physician, including but not limited to a Physician affiliated with a specialty care center for the treatment of cancer, when the attending Physician provides a written referral to a non-participating Physician. If the Insured receives a second medical opinion from a non-participating Physician without a written referral, benefits will be paid at the Out-of-Network level of benefits.

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

Benefits for Prostate Screening

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer. Benefits shall include:

1. Standard diagnostic testing, including but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for an Insured with a prior history of prostate cancer.
2. An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for an Insured:
   a Age 50 and over who is asymptomatic.
   b Age 40 and over who has a family history of prostate cancer or other prostate cancer risk factors.

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

Benefits for Prescription Drugs for the Treatment of Cancer

Benefits will be paid the same as any other Prescription Drug for Prescription Drugs for the treatment of cancer provided that the drug has been recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

1. The American Hospital Formulary Service-Drug Information.
2. The national Comprehensive Cancer Networks Drugs and Biologics Compendium.
3. Thompson Micromedex Drugdex.
4. Elsevier Gold Standard's Clinical Pharmacology.
5. Other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS) or recommended by review article or editorial comment in a major peer reviewed professional journal.

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

Benefits for Oral Chemotherapy Drugs

Benefits will be paid the same as any other Prescription Drug for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the policy; provided that the Copayment, Coinsurance, and Deductibles are at least as favorable to an Insured Person as the Copays, Coinsurance or Deductibles that apply to intravenous or injected anticancer medications.

Benefits for Medical Foods

Benefits will be paid the same as any other Prescription Drug for the cost of enteral formulas for home use, whether administered orally or via tube feeding, which are prescribed by a Physician as Medically Necessary for the treatment of specific diseases for which enteral formulas have been found to be an effective form of treatment. Specific diseases for which enteral formulas have been found to be an effective form of treatment include, but are not limited to inherited disease of amino-acid or organic metabolism; Crohn's disease; gastroesophagael reflux with failure to thrive, disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death.

Benefits will also be paid for the Usual and Customary Charges for Medically Necessary modified solid food products that are low protein or which contain modified protein for treatment of certain inherited diseases of amino acid and organic acid metabolism.

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

Benefits for Bone Mineral Density Measurements or Tests

Benefits will be paid the same as any other Sickness for bone mineral density measurements or tests and for federally approved Prescription Drugs and devices.

Bone mineral density measurements or tests, drugs and devices shall include those covered under Medicare as well as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

Individuals qualifying for benefits shall at a minimum, include individuals who meet one of the following qualifications:

1. Previous diagnosis of osteoporosis or family history of osteoporosis.
2. Symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis.
3. On a prescribed drug regimen posing a significant risk of osteoporosis.
4. Lifestyle factors to such a degree as posing a significant risk of osteoporosis.
5. Age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

Benefits for End of Life Care for Terminally Ill Cancer Patients

Benefits will be paid the same as any other Sickness for Covered Medical Expenses for acute care services at Hospitals specializing in the treatment of terminally ill patients for those Insureds diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the Insured's attending Physician) if the Insured's attending Physician, in consultation with the medical director of the Hospital, determines that the Insured's care would appropriately be provided by the Hospital.

If the Company disagrees with the admission of or provision or continuation of care for the Insured at the Hospital, the Company will initiate an Expedited External Appeal. Until such decision is rendered, the admission of or provision or continuation of the care by the Hospital shall not be denied by the Company and the Company shall provide benefits and reimburse the Hospital for Covered Medical Expenses. The decision of the External Appeal Agent shall be binding on all parties. If the Company does not initiate an Expedited External Appeal, the Company shall reimburse the Hospital for Covered Medical Expenses.

The Company shall provide reimbursement at rates negotiated between the Company and the Hospital. In the absence of agreed upon rates, the Company will reimburse the Hospital's acute care rate under the Medicare program and shall reimburse for alternate level care days at seventy-five percent of the acute care rate. Payment by the Company shall be payment in full for the services provided to the Insured. The Hospital shall not charge or seek any reimbursement from, or have any recourse against an Insured for the services provided by the Hospital except for any applicable Deductible, Copayment or Coinsurance.

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

Benefits for Mental Illness Treatment

Benefits will be paid the same as any other Sickness for Mental Illness Treatment. Outpatient care shall be provided by a Physician or facility licensed by the commissioner of mental health or operated by the office of mental health.

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

Benefits for Biologically Based Mental Illness

Benefits will be paid the same as any other Sickness for adults and children diagnosed with Biologically Based Mental Illness.

"Biologically Based Mental Illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such Biologically Based Mental Illnesses are defined as:

1. Schizophrenia/psychotic disorders.
2. Major depression.
3. Bipolar disorder.
4. Delusional disorders.
5. Panic disorder.
6. Obsessive compulsive disorder.
7. Bulimia and anorexia.

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

Benefits for Children with Serious Emotional Disturbances

Benefits will be paid the same as any other Sickness for Children with Serious Emotional Disturbances.

"Children with Serious Emotional Disturbances" means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and where there are one or more of the following:

1. Serious suicidal symptoms or other life-threatening self-destructive behaviors.
2. Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors).
3. Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage.
4. Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

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

Benefits for Autism Spectrum Disorder

Benefits will be paid the same as any other Sickness for the Medically Necessary screening, diagnosis and treatment of Autism Spectrum Disorder.

Benefits shall also include coverage for Applied Behavior Analysis up to a maximum benefit of 680 hours per Insured Person, per Policy Year.

"Autism Spectrum Disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders at the time services are rendered, including:

1. Autistic disorder.
2. Asperger's disorder.
3. Rett's disorder.
4. Childhood disintegrative disorder.
5. Pervasive developmental disorder not otherwise specified (PDD-NOS).

"Applied Behavior Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

"Behavioral Health Treatment" means counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functions of an Insured Person. Such Behavioral Health Treatment must be provided by a licensed provider. Benefits also include Applied Behavior Analysis, when provided or supervised by a behavior analyst certified pursuant to the behavior analyst certification board and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Department of Health and Education.

"Diagnosis of Autism Spectrum Disorder" means assessments, evaluations, or tests to diagnose whether an individual has Autism Spectrum Disorder.

"Pharmacy Care" means prescription drugs to treat Autism Spectrum Disorder that are prescribed by a provider legally authorized to prescribe under title eight of the education law, when prescription drugs are otherwise covered under this policy.

"Psychiatric Care" means direct or consultative services provided by a licensed psychiatrist.

"Psychological Care" means direct or consultative services provided by a licensed psychologist.

"Therapeutic Care" means services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the Insured Person, when such services are provided by licensed or certified speech therapists, occupational therapists, social workers, or physical therapists.

"Treatment of Autism Spectrum Disorder" shall include the following care and Assistive Communication Devices prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed Physician or licensed psychologist:

1. Behavioral Health Treatment.
2. Psychiatric Care.
3. Psychological Care.
4. Medical care provided by a licensed health care provider.
5. Therapeutic Care, including Therapeutic Care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for the Therapeutic Care.
6. Pharmacy Care.

In connection with Assistive Communication Devices, benefits include a formal evaluation by a speech-language pathologist to determine the need for an Assistive Communication Device. Based on the formal evaluation, benefits will be provided for the rental or purchase of an Assistive Communication Device for an Insured Person who is unable to communicate through normal means (i.e., speech or writing) when the results of the formal evaluation indicate that an Assistive Communication Device is likely to provide the Insured Person with improved communication. The Company will determine whether the device should be purchased or rented.

Examples of Assistive Communication Devices include communication boards and speech-generating devices. Benefits are limited to dedicated devices that are not useful to an Insured Person in the absence of a communication impairment. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered. Benefits will be provided for the device most appropriate to the Insured Person's current functional level.

Benefits are not provided for item such as, but not limited to, laptops, desktops, or tablet computers. However, benefits are provided for software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device.

Coverage may be denied on the basis that such treatment is being provided to the Insured Person pursuant to an individualized education plan under article 89 of the education law. The provision of services pursuant to an individualized family service plan under section 2545 of the public health law, an individualized education plan under article 89 of the education law, or an individualized service plan pursuant to the regulations of the office for persons with developmental disabilities shall not affect coverage under the policy for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

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

Benefits for Contraceptive Drugs or Devices

Benefits will be paid the same as any other Prescription Drug for prescription contraceptive drugs and devices approved by the Food and Drug Administration (FDA) or generic equivalents approved as substitutes by the FDA.

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

Coordination of Benefits Provision

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

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 90 days from the date of Injury solely result in any one of the following specific losses, the Company will pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of

Life	$10,000
Two or More Members	$10,000
One Member	$ 5,000

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

Definitions

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

COMPLICATION OF PREGNANCY means:

1. Conditions requiring Hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and will not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
2. Nonelective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

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 all of the following:

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.
7. In excess of the amount stated as a Deductible, if any.

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

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

DEPENDENT means the legal spouse of the Named Insured and their dependent-children, including legally adopted children, a child placed with the Insured pending adoption procedures, unless the child is removed from placement with the Insured prior to final adoption, and step-children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

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

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

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

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

ELECTIVE SURGERY OR ELECTIVE TREATMENT includes any surgery, service, treatment and/or supply which is deemed not to be a Medical Necessity for the treatment of a Sickness or Injury.

EMERGENCY SERVICES means, with respect to a Medical Emergency:

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

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

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

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

HOSPITAL means a short-term, acute general hospital which meets all of the following:

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.
6. If located in New York state, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395x[k]).
7. Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, or a place for convalescent, custodial, education, or rehabilatory care.

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.
5. sustained while the Insured Person is covered under this policy.

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

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital, 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 a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the Insured or others in serious jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any body organ or part.
4. Serious disfigurement of the Insured.

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

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

1. Essential for the symptoms and diagnosis or treatment of the Sickness or Injury.
2. Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury.

3. In accordance with the standards of good medical practice.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.
5. The most appropriate supply or level of service which can safely be provided to the Insured.

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

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

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

MENTAL ILLNESS TREATMENT means Medically Necessary mental health care rendered by an eligible practitioner or approved facility and which, in the opinion of the Company, is directed predominantly at treatable behavioral manifestations of a condition that the Company determines is all of the following:

1. Clinically significant behavioral or psychological syndrome, pattern, illness or disorder.
2. Substantially or materially impairs a person's ability to function in one or more major life activities.
3. Classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

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 of the following:

1. Any newly born child of an Insured provided that the person is insured under this policy.
2. A newborn adopted child of an Insured provided the person is insured under this policy on the date the adoption is effective.
3. A newborn child placed with the Insured pending adoption procedures provided the person adopting the child is insured under the policy on the date the child is placed with the Insured.

Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medial 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, including a chiropractor, 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, including a chiropractor.

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. Prescription Drugs shall not include drugs labeled, "Caution – limited by federal law to investigational use" or experimental drugs.

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

SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. 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, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

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

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

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. 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. Cosmetic procedures, except reconstructive procedures:
   - Which are incidental to or follow surgery resulting from trauma, infection, or other disease of the involved part.
   - 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.
   - To treat or correct Congenital Conditions of a covered Dependent child
   - As specifically provided in Benefits for Breast Cancer Treatment.
2. 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.
3. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - Due to Congenital Conditions.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
4. Elective Surgery or Elective Treatment.
5. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
6. Foot care in connection with the following:
   - Flat foot conditions.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Corns.

- Calluses.
- Symptomatic complaints of the feet.

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.

7. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
   This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of an infection or Injury.
   - Benefits specifically provided in the policy.
   - A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
8. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
9. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by mandatory automobile no-fault benefits.
10. Injury sustained while:
    - Participating in any interscholastic 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.
11. Investigational services or experimental treatment, except for:
    - Approved Clinical Trials.
    - Experimental or investigational treatment approved by an External Appeal Agent in accordance with Insured Persons Right to an External Appeal. If the External Appeal Agent approves benefits of an experimental or investigational treatment that is part of a clinical trial, this policy will only cover the costs of services required to provide treatment to the Insured according to the design of the trial. The Company shall not be responsible for the cost of investigational drugs or devices, the costs of non-health care services, the cost of managing research, or costs which would not be covered under this policy for non-experimental or non-investigational treatments provided in such clinical trial.
12. Participation in a riot or insurrection. Commission of or attempt to commit a felony.
13. Routine eye examinations. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury, disease process, or a Medical Necessity.
    - To benefits specifically provided in Pediatric Vision Services.
14. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
15. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
16. Supplies, except as specifically provided in the policy.
17. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
18. Treatment, service or supply which is not a Medical Necessity, subject to Article 49 of N.Y. Insurance Law.
19. 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).

FrontierMEDEX: Global Emergency Medical Assistance

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

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

Domestic Students, insured spouse and insured minor child(ren): You are eligible for FrontierMEDEX 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 FrontierMEDEX; any services not arranged by FrontierMEDEX 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. We 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 and Blood Transfers
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance Payments (when included with Your enrollment in a UnitedHealthcare **Student**Resources 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
- 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

Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

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

Services are also accessible via e-mail at operations@frontiermedex.com.

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

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

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

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed on the ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to ***My Account*** at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "create **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 **Student**Resources' environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account now includes 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.

ID Cards

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

UHCSR Mobile App

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

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

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 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. Secure a Company claim form from the Student Health Service or from the address below, fill in the necessary information, have the attending physician complete his portion of the form, fill out the form completely, attach all medical and hospital bills and mail to the address below. No claim will be paid unless a Company claim form is filled out completely and mailed to the address below.

   Submit claims for payment within 120 days after the date of service or as soon as reasonably possible.

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) date the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 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 $300 or if a dental exam reveals the need for fixed bridgework, the Insured Person may receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

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

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

Pre-Authorization

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

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

Section 2: Benefits for Pediatric Dental Services

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

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

Dental Services Deductible

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

Benefits

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

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 1 set of films every 6 months.	50%	50%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 film every 60 months.	50%	50%
Periodic Oral Evaluation (Checkup Exam) Limited to 1 every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	50%	50%

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.
Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 1 every 6 months.	50%	50%
Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50%	50%
Sealants (Protective Coating) Limited to one sealant per tooth every 36 months.	50%	50%
Space Maintainers		
Space Maintainers Limited to one per 60 months. Benefit includes all adjustments within 6 months of installation.	50%	50%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50%	50%
Periodontal Surgery (Gum Surgery) Limited to one quadrant or site per 36 months per surgical area.	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to once per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	50%	50%
Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars Limited to once per tooth per lifetime. Endodontic Surgery	50%	50%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50%	50%
Oral Surgery, including Surgical Extraction	50%	50%
Adjunctive Services		
General Services (including Emergency Treatment of dental pain) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary.	50%	50%
Occlusal guards for Insureds age 13 and older Limited to one guard every 12 months.	50%	50%
Major Restorative Services		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Fixed Prosthetics (Bridges) Limited to once per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures) Limited to one per consecutive60 months. No additional allowances for precision or semi-precision attachments.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per 24 months.	50%	50%
Implants		
Implant Placement Limited to once per 60 months.	50%	50%
Implant Supported Prosthetics Limited to once per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to once per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report Limited to once per 60 months.	50%	50%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to once per 60 months.	50%	50%
Repair Implant Abutment by Support Limited to once per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report Limited to once per 60 months.	50%	50%
MEDICALLY NECESSARY ORTHODONTICS		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.		
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	50%	50%

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.

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

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

Claim Forms

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

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.

- The date the dental disease began.
- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage the Insured Person must include the name of the other carrier(s).

To file a claim, submit the above information to the Company at the following address:
UnitedHealthcare Dental
Attn: Claims Unit
P.O. Box 30567
Salt Lake City, UT 84130-0567

Submit claims for payment within 120 days after the date of service or as soon as reasonably possible.

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

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

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

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

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

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.

Experimental, Investigational, or Unproven Service - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

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

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

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

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

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

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

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

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

Non-Network Benefits - benefits available for Covered Dental Services obtained from Non-Network Dentists

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

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

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

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-800-839-3242. 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.

Policy Deductible

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

Benefit Description

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

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

Routine Vision Examination

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

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

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

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

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

- Standard scratch-resistant coating.
- Polycarbonate lenses.

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

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

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

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

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

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	50% of the billed charge.
• Bifocal		100% after a Copayment of $40.	50% of the billed charge.
• Trifocal		100% after a Copayment of $40.	50% of the billed charge.
• Lenticular		100% after a Copayment of $40.	50% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - 160.		100% after a Copayment of $15.	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
• Eyeglass frames with a retail cost of $160 - 200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - 250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.
Contact Lenses	Limited to a 12 month supply.		
• Covered Contact Lens Selection.		100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses.		100% after a Copayment of $40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

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

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
By facsimile (fax): 248-733-6060

Submit claims for payment within 120 days after the date of service or as soon as reasonably possible.

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

Notice of Appeal Rights

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

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;
6. Copies of the State's External Appeal Instructions and Application Form; and
7. The Insured Person's right to bring a civil action in a court of competent jurisdiction.
8. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

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 a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

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

EXTERNAL INDEPENDENT REVIEW

If the Company makes an Adverse Determination or a Final Adverse Determination on the basis that the service is not a Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a Covered Medical Expense) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases) or is an Out-of-Network treatment, an Insured Person or the Authorized Representative and, in connection with a Retrospective Adverse Determination, an Insured Person's Physician, may appeal that decision to an External Appeal Agent. An External Appeal Agent is an independent entity certified by New York State to conduct such appeals.

Insured Person's Right To Appeal A Determination That A Service Is Not A Medical Necessity

If an Adverse Benefit Determination or a Final Adverse Benefit Determination is made on the basis that the service is not a Medical Necessity, an Insured Person may appeal to an External Appeal Agent if the service, procedure or treatment must otherwise be a Covered Medical Expense under the policy and:

1. the Insured Person must have received a Final Adverse Determination through the Company's internal appeal process and the Company upheld the denial;
2. the Insured Person and the Company agreed in writing to waive any internal appeal;
3. the Insured Person applied for an Expedited External Appeal at the same time as an Expedited Internal Appeal; or
4. the Company fails to adhere to claim processing requirements.

Insured Person's Rights To Appeal A Determination That A Service Is Experimental Or Investigational

If an Adverse Benefit Determination or a Final Adverse Benefit Determination is made on the basis that the service is an experimental or investigational treatment, an Insured Person may appeal to an External Appeal Agent if the service must otherwise be a Covered Medical Expense under the Policy and:

1. the Insured Person must have received a Final Adverse Determination through the Company's internal appeal process and the Company must have upheld the denial;
2. the Insured Person and the Company must agree in writing to waive any internal appeal; or
3. the Insured person has been deemed to have exhausted or is not required to complete the internal appeal process.

In addition, the Insured Person's attending Physician must certify that the Insured Person has condition or disease for which:

1. standard health services or procedures have been ineffective or medically inappropriate;
2. there does not exist a more beneficial standard service or procedure covered by the Policy; or
3. there exists a clinical trial or rare disease treatment.

In addition, the Insured Person's attending Physician must have recommended either:

1. a service or procedure that, based on two documents from available medical and scientific evidence, is likely to be more beneficial to the Insured Person than any standard covered service or procedure; or
2. a clinical trial for which the Insured Person is eligible (only certain clinical trials can be considered); or
3. in the case of a rare disease, the Insured's Authorized Representative or attending Physician may present that the requested service or procedure is likely to benefit the Insured in the treatment of the rare disease and that such benefit outweighs the risks associated with such service or treatment. In addition, the Insured Person's attending Physician must certify that the condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research network or that it affects fewer than 200,000 U.S. residents per year.

Any Physician certification provided under this section shall include a statement of the evidence relied upon by the Physician in certifying his recommendation.

For the purposes of this section, the Insured Person's attending Physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat the Insured Person's condition or disease. In addition, for a rare disease treatment, the attending Physician may not be the Insured Person's treating Physician.

Insured Person's Rights To Appeal A Determination That A Service Is Out-of-Network

If an Adverse Benefit Determination or a Final Adverse Benefit Determination is made on the basis that the Out-of-Network service is not materially different than the service available from a Preferred Provider, an Insured Person may appeal to an External Appeal Agent if the Insured Person satisfies three (3) of the following criteria:

1. The service must otherwise be a Covered Medical Expense under the Policy; and
2. The Insured Person must have requested pre-authorization for the Out-of-Network treatment; and
3. a. The Insured Person must have received a Final Adverse Determination through the Company's internal appeal process and the Company upheld the denial;
   b. The Insured Person and the Company agreed in writing to waive any internal appeal;
   c. The Insured Person applied for an Expedited External Appeal at the same time as an Expedited Internal Appeal; or
   d. The Company fails to adhere to claim processing requirements.

In addition, the Insured Person's attending Physician must certify that:

1. the Out-of-Network services is materially different from the alternate recommended service available from a Preferred Provider;
2. based on two(2) documents from available medical and scientific evidence, the Out-of-Network service is likely to be more clinically beneficial than the alternate recommended service available from a Preferred Provider; and
3. the adverse risk of the Out-of-Network service would likely not be substantially increased over the alternate recommended service available from a Preferred Provider.

For the purposes of this section, the Insured Person's attending Physician must be a licensed, board-certified or board eligible physician qualified to practice in the specialty area appropriate to treat the Insured Person for the requested Out-of-Network service.

The Insured Person does not have the right to an External Appeal for an Adverse Benefit Determination or a Final Adverse Benefit Determination related to a referral to an Out-of-Network Provider on the basis that a Preferred Provider is available to provide the particular service requested by the Insured Person.

The External Appeal Process

If, through the Company's Internal Appeal process, the Insured Person has received an Adverse Determination or a Final Adverse Determination upholding a denial of benefits on the basis that the service is not a Medical Necessity or is an experimental or investigational treatment, or is an Out-of-Network treatment, the Insured Person has 4 months from receipt of such notice to file a written request for an External Appeal. If the Insured Person and the Company have agreed in writing to waive any Internal Appeal, the Insured Person has 4 months from receipt of such waiver to file a written request for an External Appeal. If the Company fails to adhere to claim processing requirements, the Insured Person has 4 months from such failure to file a written request for an External Appeal. The Company will provide an External Appeal Application with the Adverse Determination or Final Adverse Determination issued through the Company's Internal Appeal process or its written waiver of an Internal Appeal.

The Insured Person may also request an External Appeal Application from the New York State Department of Financial Services at 1 (800) 400-8882. The completed External Appeal Application should be submitted to the New York State Department of Financial Services at the address indicated on the application. If the Insured Person or, where applicable, the Insured's Physician satisfies the criteria for an External Appeal, the New York State Department of Financial Services will forward the request to a certified External Appeal Agent.

The Insured Person and the Insured's Physician, where applicable, will have an opportunity to submit additional documentation with his request. If the External Appeal Agent determines that the information the Insured Person submits represents a material change from the information on which the Company based its denial, the External Appeal Agent will share this information with the Company in order for the Company to exercise its right to reconsider its decision. If the Company chooses to exercise this right, the Company will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Company does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Insured Person's completed application. The External Appeal Agent may request additional information from the Insured Person, the attending Physician or the Company. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the Insured Person, the attending Physician (if appropriate), and the Company in writing of its decision within two (2) business days.

If the Insured Person's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Insured Person's health, or if the attending Physician certifies that the standard External Appeal time frame would seriously jeopardize the Insured Persons's life, health or ability to regain maximum function; or if the Insured Person has received emergency services and has not been discharged from a facility and the denial concerns an admission, availability of care or continued stay, the Insured Person may request an Expedited External Appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must make a reasonable attempt to immediately notify the Insured Person, the attending Physician (where appropriate), and the Company by telephone or facsimile of that decision. The External Appeal Agent must also notify the Insured Person in writing of its decision.

If the External Appeal Agent overturns the Company's decision that a service is not a Medical Necessity or approves benefits for an experimental or investigational treatment or an Out-of-Network treatment, the Company will provide benefits subject to the other terms and conditions of this policy. Please note that if the External Appeal Agent approves benefits for an experimental or investigational treatment that is part of a clinical trial, the Policy will only cover the costs of services required to provide treatment to the Insured Person according to the design of the trial. The Company shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the Insured Person and the Company. The External Appeal Agent's decision is admissible in any court proceeding.

The Company will charge the Insured Person a fee of $25 per each External Appeal, not to exceed a total of $75 per Policy Year. The Company will waive the fee if the Company determines that paying the fee would pose a hardship to the Insured Person.

The Company will charge the Insured Person's attending Physician a fee of $50 per each External Appeal,

If the External Appeal Agent overturns the Adverse Determination or Final Adverse Determination, then the Company shall refund the fee.

Insured Person's and Insured Person's Physician's Responsibilities

The Insured Person or, as applicable, the Insured Person's Physician must initiate the External Appeal process. The External Appeal process may be initiated by filing the completed appropriate application with the New York State Department of Financial Services. The Insured Person may appoint an Authorized Representative to assist with the External Appeal request; however, the Department of Financial Services may contact the Insured Person to request written confirmation of the appointment. For Retrospective Adverse Determination appeals, the Insured Person must sign an acknowledgement of the request and sign a consent to release of medical records.

Under New York State law, the completed request for appeal must be filed within 4 months of either the date upon which written notification from the Company that it has upheld a denial of benefits is received or the date upon which written waiver of any internal appeal is received or the failure of the Company to adhere to claim processing requirements. The Company has no authority to grant an extension of this deadline.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance department at the following address:

New York State Department of Financial Services
P. O. Box 7209
Albany, NY 12224-0209
(800) 400-8882
Email: externalappealquestions@dfs.ny.gov
Website: www.dfs.ny.gov

Questions Regarding Appeal Rights

Contact Customer Service at 800-767-0700 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

Community Service Society of New York
Community Health Advocates
105 East 22nd Street, 8th floor
New York, NY 10010
(888) 614-5400
Website: http://www.communityhealthadvocates.org/

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, Texas 75380-9025
800-767-0700

Sales/Marketing Services:
UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
727-563-3400
800-237-0903
E-mail: info@uhcsr.com

For information on Dental and Vision Plans that may be available, please call 800-237-0903 or visit the Website at www.uhcsr.com

Online Services: Please visit our Website at www.uhcsr.com to buy insurance online, or to view and print Certificates, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services.

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 # 2014-201212-1.

UNIVERSITY AT ALBANY

State University of New York

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