Certificate of Coverage/Read Your Certificate Carefully

2016–2017 Domestic Graduate Student Injury and Sickness Insurance Plan

Designed Especially for the Students of

OLD DOMINION UNIVERSITY

Notice: This Plan is subject to regulation by the Virginia Department of Health and the Bureau of Insurance.

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

UnitedHealthcare®

Table of Contents

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/odu.

Eligibility

Degree seeking domestic graduate students enrolled in courses at Old Dominion University's main campus or one of the higher education centers are eligible to enroll. Graduate assistants being paid $5,000 or more per semester are eligible to enroll as subsidized graduate assistants. All other eligible graduate students may enroll as nonsubsidized graduate students. Degree-seeking domestic graduate students who reside within a 50−mile radius of campus and who are enrolled in online courses are eligible for the plan. These students have access to the Student Health Center with payment of the student health fee.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence 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 (including any child for whom the Insured must provide coverage due to a court order).

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 1, 2016. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., July 31, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, subject to the grace period, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

Extension of Benefits after Termination

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

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Pre-Admission Notification

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

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

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

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

Preferred Provider Information

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

UnitedHealthcare Choice Plus.

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

Provider Directories

Provider Directories for the UnitedHealthcare Choice Plus Network may be obtained:

a) by calling UnitedHealthcare **Student**Resources at 1-800-767-0700;
b) by logging on to the website at www.uhcsr.com/odu for information.

Virginia Service Area

All counties in Virginia are included in the UnitedHealthcare Choice Plus Network.

"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. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

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

Inpatient Expenses

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

Visits and Medically Necessary supplies to treat a Medical Emergency at an Out-of-network emergency room will be paid at the Preferred Provider Coinsurance percentage shown in the Schedule of Benefits. Out-of-Network Providers may balance bill for the amount in excess of the Preferred Allowance.

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

Standing Referrals

1. Obstetrician or Gynecologist
   Referrals are not required for any Insured seeking treatment from an obstetrician or a gynecologist.

2. Specialist
   When an Insured has an ongoing special condition and the Insured receives a referral to seek treatment from a specialist for such condition, the specialist shall be permitted to treat the Insured for the special condition without further referral. The specialist may authorize such procedures, tests, referrals, and other medical services related to the Insured's special condition. A "special condition" means a condition or disease that: (i) is life-threatening, degenerative, or disabling; and (ii) requires specialized medical care over a prolonged period of time.

3. Pain Management or Oncology
   When an Insured has been diagnosed with cancer, and the Insured receives a referral to seek treatment from a board-certified Physician in pain management or an oncologist, then the referral shall be in effect throughout the course of treatment for the Insured's cancer condition. This standing referral shall not be construed to authorize the board-certified Physician in pain management or oncologist to direct the patient to other health care services.

Continuity of Care; Termination of Provider Contracts

In the event a contract or agreement between the Company and health care provider is terminated, a provider may be permitted to continue services to an Insured Person who:

1. Was receiving care under an active course of treatment prior to the notice of termination and who requests to continue receiving care from the provider.
2. Has entered the second trimester or a pregnancy at the time of termination. Treatment may, at the Insured's option, continue through the provision of postpartum care directly related to the delivery.
3. Is determined to be terminally ill at the time of termination. Treatment shall, at the Insured's option continue for the remainder of the insured's life for care directly related to the terminal illness.

The provisions shall not apply when the provider is terminated for cause.

UnitedHealthcare Pharmacy Benefits

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

You are responsible for paying the applicable Copayments and/ or Coinsurance. Your Copayment/Coinsurance is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you or the Policyholder, except if the change amounts to a benefit reduction, the Company will provide the Policyholder with written notice of a benefit reduction sixty (60) days before it becomes effective. You will be notified of the change thirty (30) days prior to the effective date of the benefit reduction. Please access www.uhcsr.com/odu or call 1-855-828-7716 for the most up-to-date tier status.

$30 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.

$50 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.

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/odu and log in to your online account or call 1-855-828-7716.

If a non-Network pharmacy has entered into an agreement with the Company that it agrees to accept the same terms and conditions applicable to Network Pharmacies or Designated Pharmacies, including reimbursement at the rate applicable to the Network Pharmacies or Designated Pharmacies, including applicable Copayment and/or Coinsurance, as payment in full, the Insured may receive benefits on the same basis and at the same Copayment and/or Coinsurance as the Insured would from a Network Pharmacy or Designated Pharmacy.

Additional Exclusions:

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. 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.

6. 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.
7. 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 specifically provided in the policy benefits for Medical Foods.
8. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
9. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

Definitions:

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.

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 in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
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/odu 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/odu 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.

Usual and Customary Fee means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Fee includes a dispensing fee and any applicable sales tax.

Insured Person's Right to Request an Exclusion Exception for [UnitedHealthcare Pharmacy (UHCP)] Prescription Drug Benefits

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-800-767-0700. The Company will notify the Insured Person of the Company's determination within 72 hours.

Urgent Requests

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

External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-800-767-0700. The Independent Review Organization (IRO) will notify the Insured Person of the determination within 72 hours.

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-800-767-0700 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

Medical Expense Benefits – Injury and Sickness

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

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance, 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.

   Benefits include bed, meals, and special diets. Benefits also include a private room rate when Medically Necessary.

2. **Intensive Care.**
   See 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 services rendered by an anesthesiologist.
   - Drugs (excluding take home drugs) or medicines, including injectable drugs.
   - Blood or blood products.
   - Therapeutic services.
   - Nuclear medicine.
   - Oxygen.
   - Supplies.

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

Benefits include:
- Hospital services for routine nursery care during mother's normal hospital stay.
- Initial examination of the newborn.
- Circumcision of a covered male Dependent.

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

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

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

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

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 fees or charges, anesthesia agents, charges for services, and Medically Necessary medical and surgical 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.

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

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 or specialist's office or a retail health clinic (walk-ins) for the diagnosis and treatment of a Sickness or Injury. Benefits include a Physician's visit in the Insured's home. Benefits do not apply when related to surgery or Physiotherapy.

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

16. **Physiotherapy (Outpatient).**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy, including the process of restoring, maintaining, teaching, or improving the physiological, psychological, social, and vocational capabilities of patients with heart disease.
- Manipulative treatment, including spinal manipulations and other manual medical interventions for musculoskeletal Sickness or Injury only.
- Speech therapy, including correction of speech impairment or services necessary to improve or teach speech.

Benefits also include outpatient rehabilitative services and Habilitative Services provided in an outpatient rehabilitation facility, including Medically Necessary services provided by a licensed therapist.

For the purpose of this benefit:
- Occupational therapy means therapy to teach, keep, improve, or restore activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.
- Physical therapy means therapy to relieve pain; to teach, keep, improve, or restore function and prevent disability after Sickness, Injury, or loss of limb; including treatment of lymphedema.

See also Benefits for Early Intervention Services.

17. **Medical Emergency Expenses (Outpatient).**
Only in connection with a Medical Emergency as defined. Benefits will be paid for Emergency Services, as defined, which includes the following:
- Facility charge for use of the emergency room and supplies.
- Attending Physician's charges.
- X-rays.
- Laboratory procedures.
- Tests and procedures.
- Injections.

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.

Benefits include:
- X-rays.
- Mammograms.
- Ultrasound.
- Nuclear diagnostic services.
- Professional services for the reading or interpretation of the images.

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

Benefits include the administration and rental or cost of radioactive materials for the treatment of a Sickness by x-rays, radium, cobalt, or high energy particle sources.

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. Laboratory procedures include pathology services.

Benefits include the professional services for the interpretation of the lab results.

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 tests and therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy, including the introduction of dry or moist gases into the lungs to treat a Sickness or Injury.
- EKGs.
- EEGs.

Benefits also include professional services for the reading and interpretation of the test or procedure.

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 or when administered at an authorized pharmacy. Immunizations for preventive care are provided as specified under Preventive Care Services.

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

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

Other

25. **Ambulance Services.**
Benefits include coverage for the following:
- Professional ambulance services to and from the nearest facility or provider adequate to treat the condition.
- Emergency air transportation when Medically Necessary.

Benefits will be paid directly to the provider of the ambulance services upon receipt of an assignment 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.

Benefits for durable medical equipment include the rental (or purchase if less than rental) of the equipment and maintenance and necessary repairs, unless damage is due to neglect.

For the purposes of this benefit, the following are considered durable medical equipment.
- Orthopedic braces that stabilize an injured body part and braces to treat curvature of the spine, including:
  - Leg braces, including attached or built-up shoes attached to a leg brace.

    - Arm braces, back braces, and neck braces.
    - Head halters.
- External prosthetic devices and components that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part, including the cost of fitting, adjustment, and repair of the device.
- Molded therapeutic shoes for diabetics with peripheral vascular disease.
- Cochlear Implants.
- Catheters and related supplies.
- Splints.
- Nebulizers, hospital-type beds, wheelchairs, traction equipment, walkers, and crutches.
- Oxygen and equipment for its administration.

If more than one piece of equipment or device can meet the Insured's functional needs, 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.

See also Benefits for Prosthetic Devices.

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

28. **Dental Treatment.**
Dental services limited to the following:
- Medically Necessary dental services resulting from an accidental Injury provided that for an Injury occurring on or after the Insured Person's effective date of coverage, the Insured Person seeks treatment within 60 days after the Injury.
- The cost of dental services and dental appliances only when required to diagnose or treat an accidental Injury to the teeth.
- Repair of dental appliances damaged as a result of accidental Injury to the jaw, mouth, or face.
- Dental services and dental appliances furnished to an Adopted or Newborn Child when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Dental services to prepare the mouth for radiation therapy to treat head and neck cancer.
- Covered general anesthesia and hospitalization services for children under the age of 5, Insured Persons who are severely disabled, and Insured Persons who have a medical condition that requires admission to a Hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the Insured Person's treating Physician that such services are required to effectively and safely provide dental care.

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.**
Same as any other Sickness.

See also Benefits for Mental Illness and Substance Use Disorder.

30. **Substance Use Disorder Treatment.**
Same as any other Sickness.

See also Benefits for Mental Illness and Substance Use Disorder.

31. **Maternity.**
Same as any other Sickness for the Named Insured and any covered Dependent.

Benefits include the following:
- Pregnancy testing.
- Maternity related check-ups.

- Prenatal and postnatal care.
- Prenatal screenings for genetic and/or chromosomal status of the fetus.
- Hemoglobinopathies screening, gonorrhea, prophylactic medication, hypothyroidism screening, PKU screening, Rh incompatibility screening,
- Anatomical, biological, or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies.
- The cost of the delivery room and care.
- Anesthesia services rendered by an anesthesiologist to provide partial or complete loss of sensation before delivery.
- Delivery by a midwife in a home setting or birthing center in lieu of an inpatient stay.
- Postpartum inpatient care and home visits in accordance with current published guidelines prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

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

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

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

33. **Preventive Care Services.**
Medical services, including routine physical exams, routine testing, preventive testing or treatment, and screening exams or testing in the absence of Injury or Sickness, 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*.

Information regarding preventive services may be obtained from the following websites:
https://www.healthcare.gov/what-are-my-preventive-care-benefits and http://www.hrsa.gov/womensguidelines/.

Benefits include FDA-approved contraceptive drugs and devices and office visits associated with contraceptive management. Contraceptive coverage may be excluded for certain exempt religious groups.

Benefits also include:
- Nutritional counseling when received as part of a covered wellness services screening.
- Smoking and tobacco cessation counseling.
- Domestic violence screening and counseling.
- Breastfeeding/lactation counseling and equipment.
- HPV/cervical cancer screening.

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

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

Benefits will be paid for:
- Medically Necessary outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

- Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.
- Routine Diabetic foot care for the treatment of corns, calluses, and care of toenails.

See also Benefits for Diabetes.

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

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

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

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

37. **Hospice Care.**
See Benefits for Hospice Care.

38. **Inpatient Rehabilitation Facility.**
Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility, including Medically Necessary services provided by a licensed therapist. 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.

Benefits include room and board, rehabilitative services, Habilitative Services, drugs, biologicals, and supplies provided during the Skilled Nursing Facility stay.

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

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.
- Blood or blood products.

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.

See also Benefits for Clinical Trials for Treatment Studies on Cancer.

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

When a human organ or tissue transplant is provided from a living donor to a covered Insured Person, both the Insured and the donor may receive benefits. 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.

Benefits also include:

- Autologous bone marrow transplants for breast cancer.
- Necessary acquisition procedures, harvest and storage, and preparatory myeloablative therapy.

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. **Allergy Testing / Treatment.**
Same as any other Sickness for Medically Necessary allergy testing and treatment when ordered by a Physician.

Benefits include allergy serum and Physician visits for allergy shots.

45. **Dialysis.**
Benefits are limited to hemodialysis and peritoneal dialysis for the treatment of severe kidney failure or chronic poor functioning of the kidneys.

Benefits are provided for equipment, supplies, and services performed in a facility, a Physician's office, or in the Insured's home.

46. **Genetic Testing.**
Benefits are limited to Medically Necessary diagnostic genetic testing and genetic counseling when ordered by a Physician.

Benefits include Medically Necessary BRCA and fetal screenings.

47. **Infertility.**
Benefits are limited to the diagnosis and treatment of the underlying cause of the infertility.

Benefits do not include infertility treatments.

48. **Infusion Therapy.**
Benefits for the infusion therapeutic agents, medication, and nutrients, limited to the following:
- Infusion of enteral nutrition into the gastrointestinal tract.
- Infusion of prescription medication administered either intravenously or parenterally.

49. **Lymphedema.**
Benefits are payable for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, when ordered by a Physician.

50. **Medical Foods**.
Benefits are payable for nutrition infusion in the home and for special medical formulas which are the primary source of nutrition for Insureds with inborn errors of amino acid or organic acid metabolism, metabolic abnormality, or severe protein or soy allergies. Medical foods must be prescribed by a Physician and required to maintain adequate nutritional status. The written prescription must accompany the claim when submitted.

51. **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 also payable for Medically Necessary:
- Hypodermic needles and syringes.
- Supplies needed for diabetes care.

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

52. **Oral and Maxillofacial Surgery.**
Benefits are payable for:
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveoloectomy related to a tooth extraction
- Orthognathic surgery required to attain functional capacity.
- Surgical services to the hard or soft tissue of the mouth not related to the treatment of teeth and supporting structures.
- Cleft lip, cleft palate, or ectodermal dysplasia.

53. **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.

54. **Sleep Disorders.**
Same as any other Sickness for the Medically Necessary testing and treatment of sleep disorders when ordered by a Physician and performed in a certified sleep laboratory.

55. **TMJ Disorder.**
Same as any other Sickness for diagnostic and surgical treatment of temporomandibular joint disorder that is deemed Medically Necessary to attain functional capacity of the affected part.

56. **Vision Correction**.
Benefits are payable for vision correction services and for prescribed eyeglasses or contact lenses only when required as a result of surgery or covered Injury. Benefits are limited to one pair of eye glasses or contact lenses per Policy Year.

Benefits include:

- Purchase and fitting of eyeglasses or contact lenses prescribed to replace a human lens lost due to surgery or Injury.
- Pinhole glasses prescribed for use after surgery for a detached retina.
- Lenses prescribed instead of surgery for the following:
  - Contact lenses for the treatment of infantile glaucoma.
  - Corneal or scleral lenses prescribed in connection with keratoconus.
  - Scleral lenses prescribed to maintain moisture when normal tearing is not possible or not adequate.
  - Corneal or scleral lenses required to reduce a corneal irregularity other than astigmatism.
- Services for exams and replacement only if the prescription change is related to the condition that required the original prescription.

Mandated Benefits

Benefits for Pregnancy from Rape or Incest

Benefits will be paid as for any other Injury for pregnancy resulting from an act of rape or incest which was reported to the police within 7 days, or 180 days if under 13 years of age, following the incident.

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

Benefits for Mammography

Benefits will be provided for low-dose screening Mammograms for determining the presence of occult breast cancer according to the following guidelines:

1. One screening Mammogram to persons age thirty-five through thirty-nine.
2. One Mammogram biennially to persons age forty through forty-nine.
3. One Mammogram annually to persons age fifty and over.

"Mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast. The equipment used to perform the mammogram must meet the radiation protection regulations standards set forth by the Virginia Department of Health.

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

Mammograms not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Mammograms not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Pap Smears

Benefits will be provided for an annual pap smear performed by any FDA approved gynecologic cytology screening technologies.

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

Pap smears not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be Subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Pap smears not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Prostate Cancer Screening

Benefits will be provided (1) for Insureds age fifty and over and (2) for Insureds age forty and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, for one PSA test in a

twelve month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

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

PSA testing not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be Subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

PSA testing not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening. Coverage shall include an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or, in appropriate circumstances, radiologic imaging shall be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

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

Colorectal cancer screening not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Colorectal cancer screening not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Reconstructive Breast Surgery following Mastectomy

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery. The reimbursement for Reconstructive Breast Surgery will be determined according to the same formula by which charges are developed for other medical and surgical procedures.

"Mastectomy" means the surgical removal of all or part of the breast.

"Reconstructive breast surgery" means surgery performed (1) coincident with or following a Mastectomy or (2) following a Mastectomy to reestablish symmetry between the two breasts and while the Insured is covered under the policy. Reconstructive breast surgery shall also include coverage for prostheses, determined as necessary in consultation with the attending Physician and Insured, and physical complications of Mastectomy, including Medically Necessary treatment of lymphedemas.

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

Benefits for Inpatient Coverage following Mastectomy

Benefits will be paid the same as any other Sickness for a minimum of 48 hours of inpatient care following a radical or modified radical mastectomy and a minimum of 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where the attending Physician in consultation with the patient determines that a shorter period of Hospital stay is appropriate.

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

Benefits for Hysterectomy

Benefits will be paid the same as any other Sickness for a minimum of 23 hours Hospital stay for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. Nothing in this section shall be construed as requiring the total hours referenced when the attending Physician in consultation with the patient determines that a shorter period of Hospital stay is appropriate.

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

Benefits for Mental Illness and Substance Use Disorder

Benefits will be paid the same as any other Sickness for inpatient, outpatient and partial hospitalization for Mental Illness and Substance Use Disorder services as follows:

1. Treatment for an adult as an Inpatient at a Hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility.
2. Treatment for a child or adolescent as an Inpatient at a Hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility.
3. Inpatient benefit may be converted when Medically Necessary at the option of the person or the parent, as defined in Virginia Statute 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage.

Benefits will be paid the same as any other Sickness for outpatient Mental Illness and Substance Use Disorder services for outpatient treatment of an adult, child or adolescent. Medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness. If all covered expenses for a visit for outpatient Mental Illness or Substance Use Disorder treatment apply toward any Deductible required by the policy, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy.

Benefits also include:

1. Diagnosis and treatment of psychiatric conditions.
2. Individual psychotherapy.
3. Group psychotherapy.
4. Psychological testing.
5. Counseling with family members to assist with the Insured's diagnosis and treatment.
6. Convulsive therapy treatment.

Benefits for Inpatient services for Substance Use Disorder, eating disorders, and the like must be provided in a Hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24-hour-a-day nursing care. Benefits are not provided for care received from a residential treatment facility or other non-skilled, sub-acute care setting if the services are custodial, residential, or domiciliary in nature.

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

Benefits for Diabetes

Benefits will be paid for diabetes equipment and supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

As provided in the benefit, diabetes equipment and supplies shall not be considered durable medical equipment under this policy.

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

Benefits for Clinical Trials for Treatment Studies on Cancer

Benefits will be paid the same as any other Sickness for Patient Costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the Insured for purposes of a clinical trial. Patient cost does not include (1) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (2) costs associated with managing the research associated with the clinical trial, or (3) the cost of the investigational drug or device.

Coverage for Patient Costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial. The treatment shall be provided by a clinical trial approved by:

1. The National Cancer Institute (NCI); An NCI cooperative group or an NCI center.
2. The Federal Food and Drug Administration (FDA) in the form of an investigational new drug application.
3. The federal Department of Veterans Affairs.
4. An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

This benefit shall apply only if all the following apply:

1. There is no clearly superior, noninvestigational treatment alternative.
2. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.
3. The Insured and the Physician or health care provider who provides services to the Insured conclude that the Insured's participation in the clinical trial would be appropriate, pursuant to procedures established by the Company, as disclosed in the policy and evidence of coverage.

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

Benefits for Prescriptions for Cancer Pain in Excess of Recommended Dosage

Benefits will be paid the same as any other Prescription Drug for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer pain. Benefits will not be denied on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia Statutes 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

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

Benefits for Prescription Drugs for Cancer Treatment and Treatment of a Covered Indication

Benefits will be paid for Prescription Drugs, whether on an inpatient or an outpatient basis, including all services that are a Medical Necessity associated with the administration of the drug, to treat cancer subject to the following provisions.

Benefits will not be denied for any drug approved by the United States Food and Drug Administration (FDA) for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia.

Benefits will not be denied for any drug prescribed to treat a covered indication so long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-reviewed Medical Literature.

"Standard reference compendia" means the American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network's Drugs & Biologics Compendium, or the Elsevier Gold Standard's Clinical Pharmacology.

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

This provision shall not be construed to do any of the following:

1. Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the specific type of cancer or indication for which the drug has been prescribed.
2. Require coverage for any experimental drug not otherwise approved for any indication by the FDA.
3. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA.
4. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

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

Benefits for Hospice Care

Benefits will be paid the same as any other Sickness for Hospice Services.

"Hospice services" shall mean a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed under Article 7 (32.1-162.1 et seq.) of Chapter 5 of Title 32.1, and shall include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.

"Individuals with a terminal illness" shall mean individuals whose condition has been diagnosed as terminal by a licensed Physician, whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care.

"Palliative care" shall mean treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

Documentation requirements shall be no greater than those required for the same service under Medicare.

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

Benefits for Home Treatment of Hemophilia and Congenital Bleeding Disorders

Benefits will be paid the same as any other Sickness for the Home Treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Benefits include coverage for the purchase of Blood Products, blood services, and Blood Infusion Equipment required for Home Treatment of routine bleeding episodes when the Home Treatment Program is under the supervision of the state-approved treatment center.

"Home treatment program" means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.

"State-approved hemophilia treatment center" means a Hospital or clinic which received federal or state Maternal and Child Health Bureau and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

"Blood infusion equipment' includes but is not limited to syringes and needles.

"Blood Product" includes but is not limited to, Factor VII, Factor VIII, Factor IX and cryoprecipitate.

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

Benefits for Treatment Involving Bones and Joints of the Head, Neck, Face or Jaw

Benefits will be paid for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw the same as for the diagnosis and treatment to any bone or joint of the skeletal structure. Such treatment must be required because of a Sickness or Injury which prevents normal function of the joint or bone and be deemed a Medical Necessity to attain functional capacity of the affected part.

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

Benefits for Prosthetic Devices

Benefits will be paid the same as any other Sickness for Medically Necessary Prosthetic Devices, including their repair, fitting, replacement, and components. When services are provided by a Preferred Provider, the Insured's portion of the coinsurance shall not exceed 30% for such Prosthetic Devices.

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

"Limb" means an arm, hand, leg, foot, or any portion thereof.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

Benefits do not include devices primarily for athletic purposes or repair or replacement due to an Insured's neglect, misuse, or abuse.

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

Benefits for Early Intervention Services

Benefits will be paid the same as any other Sickness for medically necessary Early Intervention Services. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the Company to or on behalf of the Insured during the Insured's lifetime.

"Early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for Dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act. These services are designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

No therapy visit maximums apply to occupational, physical, or speech therapy services provided under this benefit.

With the exception of visit maximums, benefits shall be subject to all other Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Newborn Infant Hearing Screening

Benefits will be provided for newborn infant hearing screenings and all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recommended by the National Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such benefits shall include any follow-up audiological examinations as recommended by a Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

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

Newborn infant hearing screenings not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Newborn infant hearing screenings not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Routine and Necessary Childhood Immunizations

Benefits will be provided for routine and necessary childhood immunizations for Dependent children from birth to thirty-six months under the Preventive Care Services benefit or under this benefit, whichever is greater.

Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other immunizations as may be prescribed by the Commissioner of Health.

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

Childhood immunizations not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Childhood immunizations not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for General Anesthesia and Hospitalization for Dental Care

Benefits will be paid the same as any other Sickness for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to an Insured who is determined by a licensed dentist in consultation with the Insured's treating Physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care and is one of the following:

1. Under the age of five.
2. Severely disabled.
3. Has a medical condition and requires admission to a Hospital or outpatient surgery facility for dental care treatment.

For purposes of this provision, a determination of Medical Necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the Insured requires the utilization of general anesthesia and the admission to a Hospital or outpatient surgery facility to safely provide the underlying dental care.

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

Benefits for Telemedicine Services

Benefits will be paid the same as any other Sickness for medically necessary healthcare services provided through Telemedicine Services.

"Telemedicine services" means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. "Telemedicine services" do not include an audio-only telephone, electronic mail message, or facsimile transmission.

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

Benefits for Orally Administered Cancer Chemotherapy Drugs

Benefits will be paid 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 Autism Spectrum Disorder

Benefits will be paid the same as any other Sickness for the Diagnosis of Autism Spectrum Disorder and the Treatment of Autism Spectrum Disorder in Insureds from age two through age ten.

“Autism Spectrum Disorder” means any pervasive developmental disorder, including:

1. Autistic disorder.
2. Asperger’s syndrome.
3. Rett syndrome.
4. Childhood disintegrative disorder.
5. Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

“Diagnosis of Autism Spectrum Disorder” means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.

“Treatment of Autism Spectrum Disorder” shall be identified in a treatment plan and includes the following medically necessary care prescribed or ordered by a Physician or Psychologist for an Insured diagnosed with Autism Spectrum Disorder:

1. Behavioral health treatment including professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning an individual.
2. Pharmacy care including medications prescribed by a Physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.
3. Psychiatric care and Psychological care such as direct or consultative services provided by a licensed Psychiatrist or Psychologist.
4. Therapeutic care provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or clinical social worker.
5. Applied behavior analysis when provided or supervised by a board certified behavior analyst licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

Except for Inpatient services, if an Insured is receiving treatment for an Autism Spectrum Disorder, the company shall have the right to review that treatment, but not more than once every 12 months, unless the Company and the Insured's Physician agree that more frequent review is necessary.

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

Mandated Offers of Coverage

Benefits for Child Health Supervision Services

Benefits will be paid the same as any other Sickness for Child Health Supervision Services provided at approximately the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, and 6 years. Benefits shall be payable on a per visit basis to one health care provider per visit.

"Child health supervision services" means the periodic review and supervision of a child's physical and emotional status by a licensed and qualified Physician. A review shall include but not be limited to a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards.

The policy Deductible, Copayment, Coinsurance or other dollar limitations will not be applied to this benefit.

Benefits for Treatment of Breast Cancer by Dose-Intensive Chemotherapy/ Autologous Bone Marrow Transplants or Stem Cell Transplants

Benefits will be paid the same as any other Sickness for treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college, including but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

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

Benefits for Treatment of Morbid Obesity

Benefits will be paid the same as any other Sickness for the treatment of Morbid Obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for long-term reversal of Morbid Obesity. For the purpose of this provision, "morbid obesity" means (a) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (b) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (c) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

Benefits shall be subject to all Deductible, Copayment, 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.

Eligible medical, surgical or hospital plans with which coverage will be coordinated include:

(a) Group insurance contracts and subscriber contracts.
(b) Uninsured arrangements of group or group-type coverage.
(c) Group coverage through closed panel plans.
(d) Group-type contracts, including blanket contracts.
(e) The medical care components of long-term care contracts, such as skilled nursing care.
(f) Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

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 Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of

Life	$ 15,000
Two or More Members	$ 15,000
One Member	$ 7,500
Thumb or Index Finger	$ 3,750

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.

Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 60 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

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

Definitions

ADOPTED OR NEWBORN CHILD means: 1) a newly born child of the Insured from the moment of birth provided that person is insured under this policy; 2) a child adopted by the Insured provided the person adopting the child is insured under this policy on the date the adoption becomes effective; and 3) a child who has been placed for adoption with the Insured provided the person adopting the child is insured under the policy on the date the child is placed with the Insured. Such child will be covered under the policy for the first 31 days after: 1) birth of the newly born child; 2) the effective date of adoption of the child; and 3) the date of placement of the child for adoption, unless the placement is disrupted prior to final decree of adoption, and the child is removed from placement with the Insured. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity, nursery care; inpatient and outpatient dental services and dental appliances, oral surgical services, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia. 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 date of birth, adoption, or placement for adoption: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the date of birth, adoption, or placement for adoption.

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

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

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

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

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.
Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

CUSTODIAL CARE means services that are any of the following:

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

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any 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, which includes any son, daughter, stepchild, adopted child, child placed for adoption, foster child, or any child for whom the Insured must provide coverage due to court order. 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 intellectual disability 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 means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means with respect to a Medical Emergency:

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

HABILITATIVE SERVICES means coverage for health care services that help a person keep, learn or improve skills and functioning for daily living.

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.

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

For the treatment of Mental Illness and Substance Use Disorders, Hospital also means a licensed alcohol or drug rehabilitation facility, intermediate care facility, and mental health treatment facility. These facilities are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

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

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

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

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

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts, including but not limited to a doctor, nurse, physician's assistant, chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist, speech pathologist, certified nurse midwife, marriage and family therapist or licensed acupuncturist who provides care within the scope of his/her license, other than a member of the person's immediate family.

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

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

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

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

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

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.

STABILIZE means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

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

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

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

Exclusions and Limitations

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

1. Acupuncture, except as specifically provided in the Schedule of Benefits.
2. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct Congenital Conditions of an Adopted or Newborn Child.
3. 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 use facilities for domiciliary or Custodial Care.
4. Dental treatment, except:
   - As provided in the Dental Treatment benefit.
   - As specifically provided in the Schedule of Benefits.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
5. Elective Surgery or Elective Treatment.
6. Health spa or similar facilities. Strengthening programs.
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 Benefits for Newborn Infant Hearing Screening.
8. Hirsutism. Alopecia.
9. Hypnosis.
10. Immunizations for work.
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
12. Injury or Sickness outside the United States and its possessions, except for a Medical Emergency when traveling for academic study abroad programs.
13. Investigational services.
14. Lipectomy.
15. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
16. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
    - Immunization agents, except as specifically provided in the policy. Biological sera.
    - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.

- Anorectics - drugs used for the purpose of weight control.
- Fertility agents, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene.
- Growth hormones.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

17. Reproductive/Infertility services including but not limited to the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing, except as specifically provided in Genetic Testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Female sterilization procedures, except as specifically provided in the policy.
    - Vasectomy.
    - Reversal of sterilization procedures.
    - Sexual reassignment surgery.
18. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in Benefits for Clinical Trials for Treatment Studies on Cancer.
19. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To eyeglasses or contact lenses as described under Vision Correction in the policy.
20. Routine Adopted or Newborn Child Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
21. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
22. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
    This exclusion does not apply to:
    - Maxillary or mandibular frenectomy when not related to a dental procedure.
    - Alveolectomy related to tooth extraction.
    - Orthognathic surgery required to attain functional capacity.
    - Surgical services on the hard or soft tissue of the mouth for purposes not related to treat or help teeth and supporting structures.
    - Treatment of cleft lip, cleft palate, or ectodermal dysplasia.
23. Naturopathic services.
24. 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.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
27. 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).
28. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Schedule of Benefits.

General Provisions

Representations: All statements made by the Policyholder or by persons insured under the policy shall be deemed representations and not warranties. No written statement made by any Insured Person shall be used in any contest unless a copy of the statement is furnished to the Insured Person or to his beneficiary or personal representative.

Grace Period: A grace period of thirty-one days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Company receives written notice of discontinuance in accordance with the terms of the policy and in advance of the date of discontinuance.

Incontestability: No statement made by any person insured under the policy relating to his insurability or the insurability of his insured Dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1) after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2) unless the statement is contained in a written instrument signed by him. This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

Notice of Claim: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company with information sufficient to identify the Named Insured shall be deemed notice to the Company.

Claim Forms: Claim forms are not required.

Time of Payment of Claim: Indemnities payable under this policy for any loss will be paid within 60 days after receipt of due written proof of such loss.

Payment of Claims: All benefits are payable to the Insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parents, guardian, or other person actually supporting him. Subject to any written direction of the Insured, all or a portion of any benefits payable under this policy may be paid directly to the Hospital, Physician or person rendering the service or treatment. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

Payments made to the Insured, or to his designated beneficiary or beneficiaries, for a claim for services received from an Out-of-Network Provider should be applied to the claim from such Out-of-Network Provider.

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

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

UnitedHealthcare Global: Global Emergency Services

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

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

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

Key Services include:

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

- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to $5,000.00 payment
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

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

To access services please call:
(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 assistance@UHCGlobal.com.

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

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

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

Online Access to Account Information

UnitedHealthcare **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.

Notice of Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason, please contact the insurance company issuing this insurance at P. O. Box 809025, Dallas, Texas 75380-9025 or call toll-free at 1-800-767-0700. If you have been unable to contact or obtain satisfaction from the insurance company, you may contact:

Virginia State Corporation Commission
Life and Health Division
Bureau of Insurance
P. O. Box 1157
Richmond, Virginia 23218
Telephone: (804) 371-9691
Toll-Free: 1-877-310-6560
TDD: (804) 371-9206
Fax: (804) 371-9944

Written correspondence is preferable so that a record of your inquiry is maintained.

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

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

2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number (insured's insurance company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.

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

Submit the above information to the Company by mail:

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

Pediatric Dental Services Benefits

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

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

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

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

Pre-Authorization

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

Section 2: Benefits for Pediatric Dental Services

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

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

Dental Services Deductible

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

Out-of-Pocket Maximum

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

Benefits

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

Benefit Description and Limitations	**Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.**	**Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.**
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	50%	50%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	50%	50%
Periodic Oral Evaluation (Checkup Exam) Limited to 1 time per 6 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.	50%	50%
Diagnostic Casts	50%	50%
Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 1 time per 6 months.	50%	50%
Fluoride Treatments Limited to 1 treatment per 6 months. Treatment should be done in conjunction with dental prophylaxis.	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.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	50%	50%
Space Maintainers (Spacers) 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 1 quadrant or site per 24 months per surgical area.	50%	50%
Gingivectomy or Gingivolplasty Limited to 1 time per quadrant per 24 months.	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.	50%	50%
Full Mouth Debridement Limited to 1 time per 12 months.	50%	50%
Osseous Surgery Limited to 1 time per quadrant per 60 months.	50%	50%
Provision Splinting	50%	50%
Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars Limited to 1 time per tooth per lifetime. Includes: • Pulp caps, pulpal therapy, pulpal regeneration. • Apicoectomy/periradicular surgery. 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%
Tooth Reimplantation and/or Stabilization	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.
Adjunctive Services		
General Services (including Dental Emergency treatment) Covered as a separate benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guards limited to 1 guard every 12 months.	50%	50%
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.		
Inlays/Onlays/Crowns (Partial to Full Crowns) (Includes temporary crown) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Protective Restorations	50%	50%
Veneers Limited to 1 time per tooth per 60 months.	50%	50%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 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 1 per 6 months.	50%	50%
Implants		
Implant Placement Limited to 1 time per 60 months.	50%	50%
Implant Supported Prosthetics Limited to 1 time per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	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.
Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium Limited to 1 time per 60 months.	50%	50%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	50%	50%
MEDICALLY NECESSARY ORTHODONTICS		
Benefits for severe, dysfunctional, 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

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. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the policy.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

Claim Forms

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

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

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

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

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

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

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the policy is in effect, are determined as stated below:

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

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

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

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

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined 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.

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

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

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

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits

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

Non-Network Benefits

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

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.

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.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

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

This benefit includes:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

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.		

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
• 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.
Lens Extras	Once per year.		
• Polycarbonate Lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% 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.
• 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.
Low Vision Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Services, the Insured will be required to pay all billed charges at the time of service. The Insured may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
• Low Vision Testing		100% of the billed charge.	75% of the billed charge.
• Low Vision Therapy		100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided 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

Reimbursement for Low Vision Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060

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

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

Notice of Appeal Rights

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

What to Do if the Insured Person Has a Question

Contact Customer Service at the telephone number shown on the Insured Person's ID card. Customer Service representatives are available to take the Insured Person's call during regular business hours, Monday through Friday.

What to Do if the Insured Person Has a Complaint

Contact Customer Service at the telephone number shown on the Insured Person's ID card. Customer Service representatives are available to take the Insured Person's call during regular business hours, Monday through Friday.

If the Insured Person would rather send the complaint to the Company in writing, the Customer Service representative can provide the Insured Person with the appropriate address.

If the Customer Service representative cannot resolve the issue to the Insured Person's satisfaction over the phone, the representative can help the Insured Person prepare and submit a written complaint. The Company will notify the Insured Person of our decision regarding the complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for benefits are those requests that require prior notification or benefit confirmation prior to receiving medical care. Concurrent review requests are considered pre-service requests. "Concurrent review" means utilization review conducted during the Insured Person's stay or course of treatment in

- A facility;
- The office of a health care professional; or
- Other inpatient or outpatient health care setting.

How to Request an Appeal

If the Insured Person disagrees with either a pre-service request for benefits determination or a post-service claim determination, the Insured Person can contact the Company in writing to formally request an appeal.

The request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason the Insured Person believes the claim should be paid.
- Any documentation or other written information to support the request for claim payment.

The Insured Person's first appeal request must be submitted to the Company within 180 days after the Insured Person receives the denial of a pre-service request for benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. The Company may consult with, or seek the participation of, medical experts as part of the appeal resolution process. The Insured Person consents to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, the Insured Person has the right to reasonable access to and

copies of all documents, records and other information relevant to the claim for benefits. In addition, if any new or additional evidence is relied upon or generated by the Company during the determination of the appeal, the Company will provide it free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for benefits, see Urgent Appeals that Require Immediate Action below.

The Insured Person will be provided written or electronic notification of the decision on the appeal as follows:

- For appeals of pre-service requests for benefits as identified above, the first level appeal will be conducted and the Insured Person will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for benefits. If the Insured Person is not satisfied with the first level appeal decision, the Insured Person has the right to request a second level appeal. The second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and the Insured Person will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision. The Company will provide continued benefits pending the outcome of an internal appeal of a concurrent review decision.

- For appeals of post-service claims as identified above, the first level appeal will be conducted and the Insured Person will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If the Insured Person is not satisfied with the first level appeal decision, the Insured Person has the right to request a second level appeal. The second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and the Insured Person will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that the Company's decision is based only on whether or not benefits are available under the Policy for the proposed treatment or procedure including the Company's determination that a treatment, device, or pharmacological regimen is not covered because it is an Experimental or Investigational Service or Unproven Service. The Company does not determine whether the pending health service is necessary or appropriate. That decision is between Insured Person and the Insured Person's Physician.

The Insured Person may have the right to external review through an Independent Review Organization (IRO) upon the exhaustion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Company's decision letter.

Concurrent Review Requests

Reduction or termination of approved treatment to be provided over time or over a number of treatments constitutes an adverse benefit determination. In such cases, the Company must notify the Insured Person sufficiently in advance to allow the Insured Person to file an internal appeal and obtain a determination before benefits are reduced or terminated.

The Company will provide continued benefits pending the outcome of an internal appeal of a concurrent review decision.

The Insured Person will be provided written or electronic notification of the decision on the appeal as follows:

- For procedures associated with urgent concurrent review requests for benefits, including urgent care appeal requests for extension of time or number of treatments, see Urgent Appeals that Require Immediate Action below.
- For all other non-urgent review requests, see Pre-service Requests for Benefits and Post-service Claim Appeals above.

Urgent Appeals that Require Immediate Action

The Insured Person's appeal may require immediate action if a delay in treatment could significantly increase the risk to the Insured Person's health, or the ability to regain maximum function, or cause severe pain. In these urgent situations, the Insured Person may request that the Company handle the appeal on an urgent basis, even if the Insured Person has already requested a standard appeal (outlined in the section above, "Pre-service Requests for benefits and Post-service Claim Appeals"). When this occurs:

- The appeal does not need to be submitted in writing. The Insured Person or the Insured Person's Physician should call the Company as soon as possible.
- The Company will provide the Insured Person with a written or electronic determination within 72 hours following receipt of the request for review of the determination, taking into account the seriousness of the Insured Person's condition.
- If the Company needs more information from the Insured Person or the Insured Person's Physician to make a decision, the Company will notify the Insured Person or the Insured Person's Physician as soon as possible, but not later than 24 hours after receipt of the request, of the specific information necessary to complete the Company's review. The Insured Person or the Insured Person's Physician will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the requested information. The Company will notify the Insured Person and the Insured Person's Physician of the decision not later than 48 hours after the earlier of 1) the Company's receipt of the specified information or 2) the end of the period afforded to provide the requested information.

The Company will provide continued benefits pending the outcome of an internal appeal of a concurrent review decision.

If the Insured Person has requested an urgent internal appeal, the Insured Person may also, at the same time, request an expedited external review when the appeal involves a medical condition for which the time frame for completion of an urgent internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function. The process for submitting an expedited external appeal is described below under Expedited External Review.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries for non-urgent situations.

Exhaustion of Internal Appeal Process

The Insured Person must exhaust the internal appeal process before submitting a request for external review as described below under Virginia External Review Program. The internal appeal process is considered exhausted when:

- The Insured Person has completed the standard internal appeals process as described above under Pre-service Requests for Benefits and Post-service Claim Appeals.
- The Insured Person did not receive a decision from the Company within the required time frame concerning a standard internal appeal.
- The Insured Person has requested an urgent internal appeal as described under Urgent Appeals that Require Immediate Action, in which case the Insured Person may also make a written or verbal request for an expedited external review (see Expedited External Review below).
- The Company waived the requirement to exhaust the internal appeal process.
- The Company violated Virginia internal appeal requirements, except where such violation is a "de minimus" violation, which means the violation does not cause, and is not likely to cause, prejudice or harm to the Insured Person so long as the Company demonstrates that the violation was for good cause or due to matters beyond the Company's control and that the violation occurred in the context of an ongoing, good faith exchange between the Insured Person and the Company. The Insured Person may:
- Request written explanation of the violation from the Company, and the Company will provide written explanation within 10 days of receipt of the request.
- Request IRO review to determine if the Company has violated Virginia internal appeal requirements. The IRO will provide a written response to the Insured Person, the Company and the commission within 10 days of receipt of the request. If rejected, within 5 days the Company must notify the Insured Person of the right to resubmit and pursue an internal appeal.

Office of the Managed Care Ombudsman/Office of Licensure and Certification

If the Insured Person has any questions regarding the appeals processes outlined above or other grievances concerning health care coverage issues that have not been satisfactorily addressed by the Company, the Insured Person may contact the Office of the Managed Care Ombudsman for assistance at any time as follows:

Office of the Managed Care Ombudsman
P.O. Box 1157
Richmond, VA 23218
(877) 310-6560
E-mail: Ombudsman@scc.virginia.gov

In addition, if the Insured Person has any questions regarding an appeal or grievance concerning provider quality of care issues that have not been satisfactorily addressed by the provider or the Company, the Insured Person may contact the Office of Licensure and Certification for assistance at any time as follows:

Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233-1463
Telephone: (800) 955-1819 or (804) 367-2106
Fax: (804) 527-4503
E-mail: mchip@vdh.virginia.gov

Virginia External Review Program

If, after exhausting the internal appeals, as described above under Exhaustion of Internal Appeal Process, the Insured Person is not satisfied with the determination made by the Company, or if the Company fails to respond to the appeal in accordance with applicable regulations regarding timing (within 15 days of the Company's receipt of the second-level pre-service appeal or within 30 days of the Company's receipt of the second-level post-service appeal), the Insured Person may be entitled to request an external review of the Company's determination. This process is administered by the Virginia Bureau of Insurance.

If one of the above conditions is met, the Insured Person may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons (the service, treatment or procedure does not meet requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness).
- The exclusions for Experimental or Investigational Services or Unproven Services.
- As otherwise required by applicable law.

If the Insured Person wishes to appeal the Company's final decision as described above, the Insured Person or the Insured Person's representative may file a request for a standard external review in writing with the Virginia Bureau of Insurance. If, in urgent situations as detailed below, the Insured Person wishes to file a request for an expedited external review, the Insured Person or the Insured Person's representative may do so by sending a written request to the Virginia Bureau of Insurance's address. The Company will provide to the Insured Person, at the time a final adverse decision is reached, a copy of the Virginia Bureau of Insurance's external review request form, which contains the address and information for requesting an external review.

An external review will be performed by an Independent Review Organization (IRO). There are two types of external reviews available:

- A standard external review.
- An expedited external review.

A request for a standard external review must be made within 120 days after the FINAL adverse determination is received and must include a general release for all medical records pertinent to the external review. An expedited external review in urgent situations may be requested as detailed below under Expedited External Review. If one of the following circumstances applies, the Insured Person may request an external review prior to exhausting the internal appeal process:

- The Insured Person did not receive a decision from the Company within the required time frame concerning a standard internal appeal.
- The Company waived the requirement to exhaust the internal appeal process.

- In the case of an expedited external review request, for the reasons described below under Expedited External Review.

If the Insured Person has questions about the external review process, the Insured Person may contact the Virginia Bureau of Insurance directly at:

Bureau of Insurance - External Review
P.O. Box 1157
Richmond, VA 23218
(877) 310-6560
E-mail: externalreview@scc.virginia.gov

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by the Company of the request to ensure the Insured Person's request meets the eligibility requirements for external review.
- A referral of the request by the Company to the Virginia Bureau of Insurance.
- Assignment of an IRO by the Virginia Bureau of Insurance.
- A decision by the IRO.

Within five business days following receipt of the request from the Virginia Bureau of Insurance, the Company will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that the Company may process the request.

After the Company completes the preliminary review, the Company will issue a notification in writing to the Insured Person, the Insured Person's representative, if applicable, and the Virginia Bureau of Insurance. If the request is eligible for external review, the Virginia Bureau of Insurance will assign an IRO to conduct such review.

The Virginia Bureau of Insurance will notify the Insured Person in writing of the request's eligibility and acceptance for external review and provide the name of the assigned IRO. The Insured Person may submit in writing to the IRO within five business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by the Insured Person after five business days.

The Company will provide to the assigned IRO the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Company.
- All other information or evidence that the Insured Person or the Insured Person's Physician submitted. If there is any information or evidence the Insured Person or the Insured Person's Physician wish to submit that was not previously provided, the Insured Person may include this information with the external review request and the Company will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Company. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and the Insured Person agrees). The IRO will deliver the notice of Final External Review Decision to the Insured Person, the Insured Person's representative and the Company, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing our determination, the Company will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Company will not be obligated to provide benefits for the health care service or procedure.

The written ruling of the IRO is final and binding on both the Insured Person and the Company.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances the Insured Person may file an expedited external review before completing the internal appeals process.

The Insured Person may make a written request for an expedited external review if the Insured Person receives either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an urgent internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and the Insured Person has filed a request for an urgent internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request from the Virginia Bureau of Insurance, the Company will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the Company may process the request.

After the Company completes the review, the Company will immediately send a notice in writing to the Insured Person. Upon a determination that a request is eligible for expedited external review, the Virginia Bureau of Insurance will assign an IRO in the same manner utilized to assign standard external reviews to IROs. The Company will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Company. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request except that, for an expedited external review concerning Experimental or Investigational Services or Unproven Services, the IRO will provide notice of the final external review decision within 48 hours after the date it receives an opinion from all assigned clinical reviewers, who will have up to five days to provide an opinion to the IRO. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to the Insured Person and to the Company.

The written ruling of the IRO is final and binding on both the Insured Person and the Company.

The Insured Person may contact the Company at the toll-free number on the Insured Person's ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700

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

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

This Certificate is based on Policy # 2016-284-1.

Schedule of Medical Expense Benefits

Old Dominion University

2016-284-1

METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 84.139%

Injury and Sickness Benefits

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

Deductible Preferred Providers	**$200 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network	**$400 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Providers	**90% of Preferred Allowance except as noted below**
Coinsurance Out-of-Network	**50% of Usual and Customary Charges except as noted below**
Out-of-Pocket Maximum Preferred Providers	**$4,000 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Providers	**$8,000 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$7,000 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$14,000 (For all Insureds in a Family, Per Policy Year)**

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

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

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

Deductible: The Per Insured Person Deductible applies to each person covered under the policy each Policy Year.

Out-of-Pocket Maximum: The Per Insured Person Out-of-Pocket Maximum applies to each person covered under the policy each Policy Year. After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year for that person. However, after the Out-of-Pocket maximum for Insured Persons in a family collectively totals the For all Insureds in a Family Out-of-Pocket Maximum in a Policy Year, Covered Medical Expenses will be paid at 100% for any insured family member for the remainder of the Policy Year. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health 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 In-Network 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 Provider
Room and Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness

Inpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing Payable within 14 working days prior to admission.	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance $20 Copay per visit	Usual and Customary Charges $20 Deductible per visit
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Early Intervention Services.	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. The Copay will be waived if admitted to the Hospital.	90% of Preferred Allowance $100 Copay per visit	90% of Preferred Allowance $100 Copay per visit (Insured may be balance billed for remainder of Out-of-Network Provider charges.)
Diagnostic X-Ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Prescription Drugs	UnitedHealthcare Pharmacy (UHCP) $30 Copay per prescription for Tier 1 $40 Copay per prescription for Tier 2 $50 Copay per prescription for Tier 3 up to a 31 day supply per prescription Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.	No Benefits

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	Preferred Allowance	90% of Usual and Customary Charges
Durable Medical Equipment When services for Prosthetic Devices are provided by a Preferred Provider, the Insured's portion of the Coinsurance shall not exceed 30% for such Prosthetic Devices.	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees	Preferred Allowance	Usual and Customary Charges
Dental Treatment	Preferred Allowance	90% of Usual and Customary Charges
Mental Illness Treatment See also Benefits for Mental Illness and Substance Use Disorder	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment See also Benefits for Mental Illness and Substance Use Disorder	Paid as any other Sickness	Paid as any other Sickness
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	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	100% of Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery Following a Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See also Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Preferred Allowance	Usual and Customary Charges
Hospice Care See Benefits for Hospice Care	Paid as any other Sickness	Paid as any other Sickness
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 See Also Benefits for Clinical Trials for Treatment Studies on Cancer	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Allergy Testing / Treatment	Paid as any other Sickness	Paid as any other Sickness
Dialysis	Paid as any other Sickness	Paid as any other Sickness
Genetic Testing	Paid as any other Sickness	Paid as any other Sickness
Infertility	Paid as any other Sickness	Paid as any other Sickness
Infusion Therapy	Paid as any other Sickness	Paid as any other Sickness
Lymphedema	Paid as any other Sickness	Paid as any other Sickness
Medical Foods	Preferred Allowance	Usual and Customary Charges
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges
Oral and Maxillofacial Surgery	Paid as any other Sickness	Paid as any other Sickness
Ostomy Supplies	Preferred Allowance	Usual and Customary Charges
Sleep Disorders	Paid as any other Sickness	Paid as any other Sickness
TMJ Disorders	Paid as any other Sickness	Paid as any other Sickness
Vision Correction	Preferred Allowance	Usual and Customary Charges

Other	Preferred Provider	Out-of-Network Provider
Acupuncture in Lieu of Anesthesia	Preferred Allowance	Usual and Customary Charges
Second Surgical Opinion	Paid as any other Sickness	Paid as any other Sickness
Bone Marrow and Stem Cell Transplants for Breast Cancer Benefit See Benefits for Treatment of Breast Cancer by Dose-Intensive Chemotherapy / Autolgous Bone Marrow Transplants or Stem-Cell Transplants	Paid as any other Sickness	Paid as any other Sickness
Diagnostic Testing for Learning Disabilities	Preferred Allowance	Usual and Customary Charges
Morbid Obesity Treatment	Paid as any other Sickness	Paid as any other Sickness