



2016–2017 Student Injury and Sickness Insurance Plan

Designed Especially for Undergraduate and Grad Special Students Attending

UNIVERSITY OF NEVADA RENO



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Privacy Policy

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

Eligibility

All registered undergraduate students enrolled in 9 or more credit hours and who have paid the health service fee are eligible to enroll in this insurance Plan. Any grad special students taking 6 or more credit hours are eligible to enroll in this insurance plan.

Students on Medical Leave are eligible to enroll on a voluntary basis for continued coverage under this Plan for only the first term immediately following medical withdrawal, provided they were enrolled in this Plan for the term prior to the leave.

Students must actively attend classes for at least the first 45 days after the date for which coverage is purchased. Home study, correspondence and online courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

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

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 15, 2016. Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 14, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

How to Enroll

To enroll in the Student Injury and Sickness Plan, log on to your MyNEVADA account and select Purchase Items under the "Other Financial" drop down under the Finances section. Purchase item fees must be paid at the time of selection. To enroll your Dependents contact UNR's student health insurance brokers, Wells Fargo Insurance Services at (800) 853-5899, Monday - Friday, 8:00 am - 5:00 pm (PST). Dependent coverage expires concurrently with that of the Insured Student, and Dependents must re-enroll when coverage terminates to maintain coverage.

To be an Insured under the Policy, the student must have paid the required premium and his/her enrollment information must be transmitted by the School or by Wells Fargo Insurance Services to the Insurer. All students must actively attend classes for 45 days following the date of enrollment in the policy, except in the case of medical withdrawal or during school authorized breaks. Medical withdrawal is only applicable to students that leave the University of Nevada Reno for reason of a covered accident or sickness. Students who withdraw from the University of Nevada Reno for medical reasons are eligible for continued coverage under this policy for only the first term immediately following medical leave, provided they were enrolled in this policy for the term prior to medical leave. Enrollment for the term immediately following medical leave must be initiated by the student and is not automatic. All applicable enrollment deadline dates apply. You must pay the applicable insurance premium.

Extension of Benefits after Termination

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

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

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

Pre-Admission Notification

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

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

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

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

Preferred Provider Information

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

UnitedHealthcare Choice Plus.

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

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

"Out-of-Network" providers have not agreed to any prearranged fee schedules. 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.

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.

Schedule of Medical Expense Benefits

Metallic Level - Gold with actuarial value of 80.241 %

Injury and Sickness Benefits

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

| | |
|--|--|
| Deductible Preferred Providers | \$250 (Per Insured Person, Per Policy Year) |
| Deductible Preferred Providers | \$500 (For all Insureds in a Family, Per Policy Year) |
| Deductible Out-of-Network | \$500 (Per Insured Person, Per Policy Year) |
| Deductible Out-of-Network | \$1,000 (For all Insureds in a Family, Per Policy Year) |
| Coinsurance Preferred Providers | 70% except as noted below |
| Coinsurance Out-of-Network | 50% except as noted below |
| Out-of-Pocket Maximum Preferred Providers | \$6,000 (Per Insured Person, Per Policy Year) |
| Out-of-Pocket Maximum Preferred Providers | \$12,000 (For all Insureds in a Family, Per Policy Year) |
| Out-of-Pocket Maximum Out-of-Network | \$12,000 (Per Insured Person, 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. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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

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

Student Health Center Benefits: The Deductible will be waived when treatment is rendered at the UNR Student Health Center (Reno). Covered Medical Expenses for services rendered at the University of Nevada – Reno Health Center that are otherwise not covered by the University of Nevada - Reno Health Fee will be paid at 100% of billed charges according to the fee schedule. The Routine/Preventive Exclusion will be waived for treatment rendered at the Student Health Center. Quantiferon TB Gold Test is covered at the Student Health Center only.

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

| Inpatient | Preferred Provider | Out-of-Network |
|---|----------------------------|-----------------------------|
| Room and Board Expense | 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 |
| 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 7 working days prior to admission. | Preferred Allowance | Usual and Customary Charges |

| Outpatient | Preferred Provider | Out-of-Network |
|---|--|--|
| 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 | Usual and Customary Charges |
| Physiotherapy Limits per Policy Year as follows: 60 visits of any combination of physical therapy, occupational therapy, speech therapy and cardiac rehabilitation therapy. | 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. | Preferred Allowance \$100 Copay per visit | 70% of Usual and Customary Charges \$100 Deductible per visit |
| 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 |

| Outpatient | Preferred Provider | Out-of-Network |
|---|--|----------------|
| Prescription Drugs Includes prenatal vitamins. Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply. | UnitedHealthcare Pharmacy (UHCP) \$15 Copay per prescription for Tier 1 \$30 Copay per prescription for Tier 2 \$70 Copay per prescription for Tier 3 up to a 31 day supply per prescription | No Benefits |

| Other | Preferred Provider | Out-of-Network |
|---|---|------------------------------------|
| Ambulance Services | Preferred Allowance | 70% of Usual and Customary Charges |
| Durable Medical Equipment | Preferred Allowance | Usual and Customary Charges |
| Consultant Physician Fees | Preferred Allowance | Usual and Customary Charges |
| Dental Treatment Benefits paid on Injury to Sound, Natural Teeth and removal of teeth to perform radiation therapy only. | Preferred Allowance | 70% of Usual and Customary Charges |
| Mental Illness Treatment | Paid as any other Sickness | Paid as any other Sickness |
| Substance Use Disorder Treatment | Paid as any other Sickness | Paid as any other Sickness |
| Maternity | Paid as any other Sickness | Paid as any other Sickness |
| Elective Abortion \$150 maximum | Preferred Allowance | 70% of Usual and Customary Charges |
| Complications of Pregnancy | Paid as any other Sickness | Paid as any other Sickness |
| Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups. | 100% of Preferred Allowance | No Benefits |
| Reconstructive Breast Surgery Following Mastectomy | Paid as any other Sickness | Paid as any other Sickness |
| Diabetes Services | Paid as any other Sickness | Paid as any other Sickness |
| Home Health Care See also Benefits for Home Health Care | Preferred Allowance | Usual and Customary Charges |
| Hospice Care | Preferred Allowance | Usual and Customary Charges |
| Inpatient Rehabilitation Facility 60 days maximum per Policy Year | Preferred Allowance | Usual and Customary Charges |
| Skilled Nursing Facility 100 days maximum per Policy Year | Preferred Allowance | Usual and Customary Charges |
| Urgent Care Center | Preferred Allowance \$50 Copay per visit | Usual and Customary Charges |
| Hospital Outpatient Facility or Clinic | Preferred Allowance | Usual and Customary Charges |
| Approved Clinical Trials See Benefits for Clinical Trials of Cancer or Chronic Fatigue Syndrome | Paid as any other Sickness | Paid as any other Sickness |
| Transplantation Services | Paid as any other Sickness | Paid as any other Sickness |
| Genetic Testing | Preferred Allowance | Usual and Customary Charges |
| Hearing Aids | Preferred Allowance | Usual and Customary Charges |
| Infertility Services | 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 |

| Other | Preferred Provider | Out-of-Network |
|---|-----------------------------|-----------------------------|
| Ostomy Supplies | Preferred Allowance | Usual and Customary Charges |
| <p>Well-Child Care No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. Except as specifically provided under Preventive Services benefit, Benefit includes routine preventive and primary care services which are services rendered to an Insured Dependent child of an Insured person; from the date of birth through the attainment of two (2) years of age. Services include: initial Hospital check-ups; other Hospital visits; physical examinations; including routine hearing and vision examinations; medical history; developmental assessments; and materials for the administration of appropriate and necessary immunizations and laboratory tests; when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> | 100% of Preferred Allowance | Paid as any other Sickness |
| <p>Women's Health Care Expense No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. Benefit includes one baseline mammogram for women, age 35-40. Women 40 and older have coverage for a mammogram annually. Covered Medical Expenses include an annual Pap Smear screening for women 18 and older. This benefit applies to services not specifically provided in Preventive Care Services or as mandated.</p> | 100% of Preferred Allowance | Paid as any other Sickness |
| <p>Diagnostic Testing for Learning Disabilities</p> | Preferred Allowance | Usual and Customary Charges |
| <p>Sexually Transmitted Disease Testing Benefits payable for routine screening only except as specifically provided under Preventive Care Services benefit.</p> | Paid as any other Sickness | Paid as any other Sickness |
| <p>Vision Exam Except as specifically provided for Pediatric Vision Services, benefits are limited to 1 visit maximum Per Policy Year. Benefits limited to charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.</p> | Preferred Allowance | Usual and Customary Charges |

UnitedHealthcare Pharmacy Benefits

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

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com/unr or call 1-855-828-7716 for the most up-to-date tier status.

\$15 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

\$30 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

\$70 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Mail order Prescription Drugs are available at 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/unr and log in to your online account or call 1-855-828-7716.

Additional Exclusions:

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically

Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

Definitions:

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.

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.

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 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/unr or call Customer Service at 1-855-828-7716.

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

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 in the Schedule of Benefits.

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

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

Inpatient

1. Room and Board Expense.

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

2. Intensive Care.

If provided in the Schedule of Benefits.

3. Hospital Miscellaneous Expenses.

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

Benefits will be paid for services and supplies such as:

- The cost of the operating room.
- Laboratory tests.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. Routine Newborn Care.

While Hospital Confined and routine nursery care provided immediately after birth.

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

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

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

5. Surgery (Inpatient).

Physician's fees for Inpatient surgery.

6. Assistant Surgeon Fees.

Assistant Surgeon Fees in connection with Inpatient surgery.

7. Anesthetist Services.

Professional services administered in connection with Inpatient surgery.

8. Registered Nurse's Services.

Registered Nurse's services which are all of the following:

- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

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

9. Physician's Visits (Inpatient).

Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

10. Pre-admission Testing.

Benefits are limited to routine tests such as:

- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the policy, major diagnostic procedures such as those listed below will be paid under the "Hospital Miscellaneous" benefit:

- CT scans.
- NMR's.
- Blood chemistries.

Outpatient

11. Surgery (Outpatient).

Physician's fees for outpatient surgery.

12. Day Surgery Miscellaneous (Outpatient).

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

13. Assistant Surgeon Fees (Outpatient).

Assistant Surgeon Fees in connection with outpatient surgery.

14. Anesthetist Services (Outpatient).

Professional services administered in connection with outpatient surgery.

15. Physician's Visits (Outpatient).

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

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

16. Physiotherapy (Outpatient).

Includes but is not limited to the following rehabilitative services (including Habilitative Services):

- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.

17. Medical Emergency Expenses (Outpatient).

Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies.

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

18. Diagnostic X-ray Services (Outpatient).

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

19. Radiation Therapy (Outpatient).

See Schedule of Benefits.

20. Laboratory Procedures (Outpatient).

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

21. Tests and Procedures (Outpatient).

Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:

- Physician's Visits.
- Physiotherapy.
- X-rays.
- Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:

- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.

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

22. Injections (Outpatient).

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

23. Chemotherapy (Outpatient).

See Schedule of Benefits.

24. Prescription Drugs (Outpatient).

See Schedule of Benefits.

Benefits will not be denied for early refills for a covered Topical Ophthalmic Product if the Insured Person is experiencing inadvertent wastage of the product due to difficulty applying the product to the eye and the Insured requests the early refill under the following conditions:

- After 21 days or more but before 30 days after receiving any 30-day supply of the product.
- After 42 days or more but before 60 days after receiving any 60-day supply of the product.
- After 63 days or more but before 90 days after receiving any 90-day supply of the product.
- The early refill is dispensed pursuant to a valid prescription which bears specific authorization to refill.

Topical Ophthalmic Product" means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a dropper.

Other

25. Ambulance Services.

See Schedule of Benefits.

26. Durable Medical Equipment.

Durable Medical Equipment must be all of the following:

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

For the purposes of this benefit, the following are considered durable medical equipment.

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of the body.

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

27. Consultant Physician Fees.

Services provided on an Inpatient or outpatient basis.

28. Dental Treatment.

Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Sound, Natural Teeth.
- Removal of teeth necessary in order to perform radiation therapy.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. Pediatric dental benefits are provided in the Pediatric Dental Services provision.

Benefits will also be paid the same as any other Sickness for general anesthesia for a Dependent child who has any of the following:

- A physical, mental, or medically compromising condition.
- Dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy.
- Is extremely uncooperative, unmanageable, or anxious.
- Sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

29. Mental Illness Treatment.

Benefits will be paid for services received:

- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

30. Substance Use Disorder Treatment.

Benefits will be paid for services received:

- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

31. Maternity.

Same as any other Sickness.

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

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

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

32. Complications of Pregnancy.

Same as any other Sickness.

33. Preventive Care Services.

Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

34. Reconstructive Breast Surgery Following Mastectomy.

Same as any other Sickness and in connection with a covered mastectomy.

Benefits include:

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

35. Diabetes Services.

Same as any other Sickness in connection with the treatment of diabetes.

Benefits will be paid for Medically Necessary:

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

36. Home Health Care.

Services received from a licensed home health agency that are:

- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person’s home.
- Pursuant to a home health plan.

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

Benefits also include Private Duty Nursing services when Medically Necessary and 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 provider. Private Duty Nursing services include teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and which is not intended to provide for long term support.

As used in 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 eight (8) hours or greater per day and does not include nursing care of less than eight (8) hours per day. Private duty nursing does not include custodial care.

See also Benefits for Home Health Care.

37. Hospice Care.

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

Hospice care includes:

- Physical, psychological, social, and spiritual care for the terminally ill Insured.

- Short-term grief counseling for immediate family members while the Insured is receiving hospice care or within six months after the Insured Person's death.

38. Inpatient Rehabilitation Facility.

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

39. Skilled Nursing Facility.

Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:

- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

40. Urgent Care Center.

Benefits are limited to:

- The facility or clinic fee billed by the Urgent Care Center.

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

41. Hospital Outpatient Facility or Clinic.

Benefits are limited to:

- The facility or clinic fee billed by the Hospital.

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

42. Approved Clinical Trials.

- See Benefits for Clinical Trials of Cancer or Chronic Fatigue Syndrome.

43. Transplantation Services.

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

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

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

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

44. Genetic Testing.

Benefits are limited to genetic testing when ordered by a Physician, determined to be Medically Necessary and which meets all of the following criteria:

- Such testing is prescribed following the Insured's history, physical exam and pedigree analysis, genetic counseling, and completion of conventional diagnostic studies and a definitive diagnosis remains uncertain and a genetic disease diagnosis is suspected.
- The Insured displays clinical features or is at direct risk of inheriting the mutation in question.
- The result of the test will directly impact the treatment being delivered to the Insured.

45. Hearing Aids.

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

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

46. Infertility Services.

Benefits for infertility services are limited to Medically Necessary laboratory studies, diagnostic procedures and six (6) cycles per Insured Person for Artificial Insemination.

47. Medical Foods.

Benefits for medical foods are limited to the following:

- Enteral formulas for use at home that are prescribed or ordered by a Physician as Medically Necessary for the treatment of Inherited Metabolic Diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat.
- Special Food Products which are prescribed or ordered by a Physician as Medically Necessary for the treatment of an Insured Person with an Inherited Metabolic Disease.

As used in this benefit, "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person. "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. The term does not include a food that is naturally low in protein.

48. Medical Supplies.

Medical supplies must meet all of the following criteria:

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

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

49. Ostomy Supplies.

Benefits for ostomy supplies are limited to the following supplies:

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

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

Mandated Benefits

Benefits for Home Health Care

Benefit shall be paid for Covered Medical Expenses arising from care at home or health supportive services if that care or service is prescribed by a Physician and would have been covered by the policy if performed in a medical facility or facility for the Dependent as defined in chapter 449 of NRS.

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

Benefits for Telehealth Services

Benefits will be paid for Telehealth services on the same basis as services provided through an in person consultation between the Insured Person and a Physician.

“Telehealth” means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.

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

Benefits for Clinical Trials of Cancer or Chronic Fatigue Syndrome

Benefits will be paid the same as any other Sickness for the medical treatment of cancer or chronic fatigue syndrome received as part of a clinical trial or study when.

- Medical treatment as part of a clinical trial when medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome. The clinical trial or study must be approved by any of the following:
 - An agency of the National Institutes of Health as set forth in 42 U.S.C §281(b).
 - A cooperative group.
 - The Food and Drug Administration as an application for a new investigational drug.
 - The United States Department of Veterans Affairs.
 - The United States Department of Defense.
- A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer.
- A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner
- There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study
- The clinical trial or study is conducted in the state of Nevada
- The policyholder or subscriber has signed, before his participation in the clinical trial or study, a statement of consent indicating that he has been informed of, without limitation:
 - The procedure to be undertaken;
 - Alternative methods of treatment; and
 - The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

Coverage for medical treatment is limited to:

- Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the policyholder or subscriber.
- The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the policy of health insurance.
- The cost of any routine health care services that would otherwise be covered under the policy of health insurance for a policyholder or subscriber participating in a Phase I clinical trial or study.
- The initial consultation to determine whether the policyholder or subscriber is eligible to participate in the clinical trial or study.
- Health care services required for the clinically appropriate monitoring of the policyholder or subscriber during a Phase II, Phase III or Phase IV clinical trial or study.
- Health care services which are required for the clinically appropriate monitoring of the policyholder or subscriber during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

The medical treatment listed above is not covered when that treatment is provided by the sponsor of the clinical trial or study free of charge to the Insured Person.

Coverage for medical treatment required by this section does not include:

- Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
- Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

- Health care services that are specifically excluded from coverage under the policyholder's or subscriber's policy of health insurance, regardless of whether such services are provided under the clinical trial or study.
- Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.
- Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur.
- Any expenses incurred by a person who accompanies the policyholder or subscriber during the clinical trial or study.
- Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the policyholder or subscriber.
- Any costs for the management of research relating to the clinical trial or study.

The clinical trial or study must be approved by any of the following:

- An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b).
- A cooperative group.
- The Food and Drug Administration as an application for a new investigational drug.
- The United States Department of Veterans Affairs.
- The United States Department of Defense.

"Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

- The Clinical Trials Cooperative Group Program; and
- The Community Clinical Oncology Program.

"Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

- Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;
- Operates a protocol review and monitoring system which conforms to the standards set forth in the Policies and Guidelines Relating to the Cancer-Center Support Grant published by the Cancer Centers Branch of the National Cancer Institute;
- Employs at least two researchers and at least one of those researchers receives funding from a federal grant;
- Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;
- Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;
- Is capable of gathering, maintaining and reporting electronic data; and
- Is capable of responding to audits instituted by federal and state agencies

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

Benefits for Off-Label Prescription Drugs

Benefits will be paid the same as any other Prescription Drug for any drug prescribed to treat an Insured Person for cancer if the drug meets the following requirements:

- Has been approved by the Food and Drug Administration for use in the treatment of an illness, disease, or other medical condition.
- Is specified in the most recent edition of or supplement to either:
 - The United States Pharmacopoeia Drug Information.
 - The American Hospital Formulary Service Drug Information.
- Is supported by at least two articles reporting the results of scientific studies that are published in scientific or medical journals.

Benefits shall include coverage of Medically Necessary services associated with the administration of the Prescription Drug.

Benefits do not include experimental drugs used for the treatment of cancer if the drug has not been approved by the Food and Drug Administration or use of a drug that is contraindicated by the Food and Drug Administration.

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

Benefits for Colorectal Cancer Screening

Benefits will be paid the same as any other Sickness for colorectal cancer screening examinations in accordance with guidelines or reports concerning colorectal cancer screening published by the American Cancer Society or by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

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

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.

Benefits for Prostate Cancer Screening

Benefits will be paid the same as any other Sickness for prostate cancer screening examinations in accordance with guidelines or reports concerning prostate cancer screening published by the American Cancer Society or by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

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

Prostate 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.

Benefits for Human Papillomavirus Vaccine

Benefits will be paid the same as any other Sickness for the administration of the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

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

Administration of the Human Papillomavirus vaccine 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.

Benefits for Cytological and Mammography Screening

Benefits will be paid the same as any other Sickness for:

- An annual cytologic screening for women eighteen (18) years of age or older.
- A baseline mammogram for women between the ages thirty-five (35) and forty (40).
- An annual mammogram for women forty (40) years of age and older.

Cytologic Screening and Mammographic Examinations 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.

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

Benefits for Contraceptives and Hormone Replacement Therapy

Benefits will be paid the same as any other outpatient Prescription Drug for FDA approved prescription contraceptive drugs or devices and any type of hormone replacement therapy.

Benefits will be paid the same as any other Sickness for outpatient contraceptive services and outpatient hormone replacement therapy services.

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

Contraceptives and hormone replacement therapy 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.

Benefits for Autism Spectrum Disorder

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Autism Spectrum Disorder. Benefits for the treatment of Autism Spectrum Disorder will be provided for Medically Necessary Habilitative or Rehabilitative Care, Prescription Care, psychiatric care, psychological care, Behavioral Therapy or Therapeutic Care when treatment is both of the following:

- Prescribed for an Insured diagnoses with an Autism Spectrum Disorder by a licensed Physician or licensed psychologist.
- Provided to an Insured Person diagnosed with an Autism Spectrum Disorder by a licensed Physician, licensed psychologist, licensed behavior analyst, or other provider that is supervised by the licensed Physician, psychologist or behavior analyst.

"Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Early intervention and school services delivered through an early intervention agency or school are not covered.

The Company may request a copy of and review a Treatment Plan for the Insured.

"Autism behavior interventionist" means a person who is registered as a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board, Inc., or its successor organization, and provides behavioral therapy under the supervision of any of the following Physicians:

- A licensed psychologist.
- A licensed behavior analyst.
- A licensed assistant behavior analyst.

"Autism Spectrum Disorder" means a neurobiological medical condition including, without limitation, autistic disorder, asperger's disorder and pervasive developmental disorder not otherwise specified.

"Behavioral Therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, Licensed Behavior Analyst, Licensed Assistance Behavior Analyst or Autism Behavior Interventionist.

"Habilitative or rehabilitative care" in this section means counseling, guidance and professional services and treatment programs, including, without limitation, Applied Behavior Analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

"Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

"Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.

"Prescription care" means medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

"Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.

"Treatment plan" means a plan to treat an Autism Spectrum Disorder that is prescribed by a licensed Physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

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

Benefits for Oral Chemotherapy

Benefits will be paid for prescribed, orally administered anticancer medications used for the treatment of cancer on a basis no less favorable than coverage provided for intravenously administered or injected cancer medications.

The combined amount of the Deductible, Copayment, and Coinsurance shall not exceed \$100 per Prescription Drug.

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.

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

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

For Loss Of

| | |
|-----------------------|----------|
| Life | \$10,000 |
| Two or More Members | \$10,000 |
| One Member | \$ 5,000 |
| Thumb or Index Finger | \$ 2,500 |

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

Definitions

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

COMPLICATION OF PREGNANCY means a condition which requires Hospital Confinement for medical treatment and: 1) if the pregnancy is not terminated, is caused by an Injury or Sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or 2) if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

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

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

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

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

If 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).

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is the Named Insured's sole spousal equivalent and shares a common residence with the Named Insured. A domestic partner relationship may be demonstrated by providing documentation prescribed by the state of Nevada declaring the domestic partnership agreement.

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

EMERGENCY SERVICES means with respect to a Medical Emergency:

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

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

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

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

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

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

INJURY means bodily injury which is all of the following:

1. directly and independently caused by specific accidental contact with another body or object.
2. unrelated to any pathological, functional, or structural disorder.
3. a source of loss.
4. treated by a Physician within 30 days after the date of accident.
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 health in jeopardy.
3. Serious impairment of bodily functions.
4. Serious dysfunction of any body organ or part.
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

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

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

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.

NEWBORN INFANT means: 1) a newly born child of the Insured from the moment of birth provided that the Insured is insured under this policy; 2) an adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption, provided the person adopting the child is insured under this policy on the date the adoption becomes effective; and 3) a child placed with the Insured for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement provided the person adopting the child is insured under this 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; or 3) the date of placement of the child for adoption. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

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

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

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

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

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

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

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

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

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

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

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

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

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality 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. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Learning disabilities. Milieu therapy. Parent-child problems.
This exclusion does not apply to benefits specifically provided in the policy.
2. Biofeedback.
3. 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.
 - Correct a congenital malformation which causes a functional impairment.
 - Treat or correct Congenital Conditions of a Newborn or adopted Infant.

4. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
5. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 - As described under Dental Treatment in the policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
6. Elective Surgery or Elective Treatment.
7. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
8. Foot care for the following:
 - Flat foot conditions.
 - Supportive devices for the foot.
 - Fallen arches.
 - Weak feet.
 - Chronic foot strain.
 - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
9. Genetic testing, except as specifically provided in the policy.
10. Health spa or similar facilities. Strengthening programs.
11. Hearing examinations. Hearing aids, except as specifically provided for in the policy. 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.
 - A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
 - Benefits specifically provided in the policy.
12. Hirsutism. Alopecia.
13. Hypnosis.
14. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
15. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
16. Injury or Sickness outside the United States and its possessions, except for a Medical Emergency when traveling for academic study abroad programs, business or pleasure.
17. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
18. Injury sustained while:
 - Participating in any intramural, club, intercollegiate, or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
19. Investigational services.
20. Lipectomy.
21. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
22. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
 - Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.

- Growth hormones.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. Reproductive/Infertility services including but not limited to the following:
- Procreative counseling.
 - Genetic counseling and genetic testing, except as specifically provided in the policy.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests, except as specifically provided in the policy.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except as specifically provided in the policy.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Reversal of sterilization procedures.
24. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.
25. 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 benefits specifically provided in the policy.
 - To one pair of eyeglasses or set of contact lenses following cataract surgery.
26. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
27. Preventive care services, except as specifically provided in the policy, including:
- Routine physical examinations and routine testing.
 - Preventive testing or treatment.
 - Screening exams or testing in the absence of Injury or Sickness.
28. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
29. Speech therapy, except as specifically provided in the policy. Naturopathic services.
30. 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.
31. Supplies, except as specifically provided in the policy.
32. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
33. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
34. 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).
35. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.

UnitedHealthcare Global: Global Emergency Services

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

Domestic students, insured spouse or Domestic Partner 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, Vaccines
- 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 **StudentResources** 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 **StudentResources'** environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

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

ID Cards

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

UHCSR Mobile App

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

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

UnitedHealth Allies

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

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

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

Submit the above information to the Company by mail:

UnitedHealthcare **StudentResources**
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.

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 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays. | 50% | 50% |
| Preventive Services | | |
| Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months. | 50% | 50% |
| Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis. | 50% | 50% |
| Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months. | 50% | 50% |
| Space Maintainers (Spacers) | 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. |
|---|---|---|
| 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) | 50% | 50% |
| Endodontics (Root Canal Therapy) | 50% | 50% |
| Periodontal Surgery (Gum Surgery) Limited to four units per 60 months per surgical area. | 50% | 50% |
| Scaling and Root Planing (Deep Cleanings) Limited to four units per 12 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% |
| Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime. | 50% | 50% |
| Oral Surgery, including Surgical Extraction | 50% | 50% |
| Adjunctive Services | | |
| General Services (including 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) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth. | 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 one unit per 6 months. | 50% | 50% |
| Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to contraindication by any provider within 91 days. | 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% |
| Abutment Supported Crown (Titanium) or Retainer Crown | 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. |
|--|---|---|
| for FPD - Titanium Limited to 1 time per 60 months. | | |
| 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 comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. | | |
| Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary. | 50% | 50% |

Section 3: Pediatric Dental Exclusions

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.
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 of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

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

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

Covered Dental Service – a Dental Service or Dental Procedure for which benefits are provided under 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. | | |
| • 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 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 of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **StudentResources**, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

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

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

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

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

Right to External Independent Review

After exhausting the Company's Internal Appeal process, the Insured Person, or the Insured Person's Authorized Representative, has the right to request an External Independent Review when the service or treatment in question:

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

Standard External Review

A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited External Review

An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and

- a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
 - b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and
 - a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

Standard Experimental or Investigational External Review

An Insured Person, or an Insured Person's Authorized Representative, may submit a request for an Experimental or Investigational External Review when the denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational.

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational External Review

An Insured Person, or an Insured Person's Authorized Representative, may submit an oral request for an Expedited Experimental or Investigational External Review when:

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
 - a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
 - b. Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly; or
2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and
 - a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - b. The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the Office of Consumer Health at the following address:

Office of Consumer Health Assistance
 Governor's Consumer Health Advocate
 555 East Washington Avenue #4800
 Las Vegas, NV 89101
 (702) 486-3587
<http://dhhs.gov/Programs/CHA>
cha@govcha.state.nv.us

Questions Regarding Appeal Rights

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

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state

Office of Consumer Health Assistance
Governor's Consumer Health Advocate
555 East Washington Avenue #4800
Las Vegas, NV 89101
(702) 486-3587
<http://dhhs.gov/Programs/CHA>
cha@govcha.state.nv.us

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare **StudentResources**
P.O. Box 809025
Dallas, Texas 75380-9025
800-767-0700
claims@uhcsr.com
customerservice@uhcsr.com

For Eligibility, Enrollment and General Questions Contact:

Wells Fargo Insurance Services USA, Inc.
Student Insurance Division
10940 White Rock Road, 2nd Floor
Rancho Cordova, CA 95670
(800) 853-5899
Fax (877) 612-7966
wfis.wellsfargo.com/UNR

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

**IMPORTANT NOTICE FOR
Nevada Consumers of Health Care, you may contact:**

**The Department of Business and Industry Division of Insurance
Monday through Friday
8am-5pm (PST)
Call toll-free at
1-888-872-3234**

**Carson City residents call
1-755-687-0700
Las Vegas residents call
1-702-486-4009**

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 number: 2016-524-1.

