



2016–2017 Student Injury and Sickness Insurance Plan

Designed Especially for the International Students of



UNIVERSITY *of*
DENVER

PLEASE NOTE:

**THIS DOCUMENT HAS
CHANGED. PLEASE SEE THE
BACK COVER FOR DETAILS**

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Dear Student,

Good health is essential for you to obtain the most benefit from participation in University life. Because the University of Denver recognizes this and desires to safeguard your good health, the University has established a two-part health care program and maintains an on-campus Health & Counseling Center for regularly enrolled students. The Health & Counseling Center provides cost effective medical and mental health services.

The University sponsors a Student Injury and Sickness Insurance Plan offered by UnitedHealthcare **StudentResources** and underwritten by UnitedHealthcare Insurance Company and described in this brochure. UHCSR DU Plan is designed to complement the services rendered at the UHCSR DU Plan. All students enrolled for one or more hours of graded credit at the University of Denver are required to carry adequate health insurance coverage. Although students with other health insurance may waive participation in the UHCSR DU Plan, we strongly encourage careful evaluation of the plan since it may be valuable as additional coverage. The UHCSR DU Plan is especially beneficial to those students who have been removed from their parents' policy because of attainment of a specified age. It is very important for out-of-state students who are currently covered under either a Health Maintenance Organization (HMO) or a Preferred Provider organization (PPO) plan to review their insurance policy for allowable benefits in the Denver area. The UHCSR DU Plan also includes out of country coverage, Dental and Vision discounts and other services.

Participation in DU's two-part health care program consisting of our Health & Counseling Fee and our Student Injury and Sickness Insurance Plan allows students to receive medical and mental health care at our UHCSR DU Plan for little or no out-of-pocket cost. Many students and parents recognize the convenience and accessibility of the Insurance Plan and purchase our plan in addition to the coverage they already have to ensure the best health care coverage situation possible at DU. If you would like to discuss how to maximize the many benefits offered under our health care program, please call us at (303)-871-2205.

The staff at the Health & Counseling Center welcomes each of you to the University of Denver. We look forward to assisting you in maintaining good health while you pursue your educational goals.

Sincerely,
Your HCC Care Team
University of Denver Health and Counseling Center

The University of Denver Student Injury and Sickness Insurance Plan

The University of Denver Student Injury and Sickness Insurance Plan has been developed especially for University of Denver students. The plan is underwritten by UnitedHealthcare Insurance Company. The plan provides coverage for illnesses and injuries that occur on and off campus locally, nationally and worldwide and includes special cost-saving features. The University of Denver is pleased to offer the plan as described in this brochure.

Please keep this brochure 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 Brochure. The Master Policy is the contract and will govern and control payment of benefits.

Some benefits are limited and should be carefully noted. If you or your healthcare provider has any questions regarding benefits, please contact UnitedHealthcare **StudentResources** at 1-866-648-8472.

By logging on to www.uhcsr.com/du, you can:

- Review coverage dates
- View claims status
- View Explanation of Benefits (EOB's)
- Find health care professionals and facilities that participate in the plan network
- Request ID Cards
- Send an email to Customer Service at your convenience

How do I create an online account?

- Go to www.uhcsr.com/du
- Select the "Create an Account" link
- Follow the simple, onscreen directions to establish an online account in minutes
- You will need your DU email address to create an online account.

Need help with creating your online account?

- Contact our Customer Service Department at 1-866-648-8472

For questions about:

- Insurance benefits
- Claims Processing

Please contact:

UnitedHealthcare **StudentResources**
PO Box 809025, Dallas, TX 75380-9025
1-866-648-8472

For questions about ID cards:

Permanent ID cards will be available by logging into your My Account online at www.uhcsr.com/du after receiving final enrollment information from the University of Denver. If you need medical attention before the ID card is available, benefits will be payable in accordance with the Master Policy. You do not need an ID card to be eligible to receive benefits. Present the ID card to the provider to facilitate claims processing.

Note: Please be advised you will receive a unique member ID number on your permanent ID card.

For lost permanent ID cards, log on to www.uhcsr.com/du and go to your account to print an ID card or call 1-866-648-8472 to request a new ID card.

For questions about:

- Enrollment process
- Waiver process
- EOBs (Explanation of Benefits) or letters requesting action on your part

Please contact:

University of Denver Health and Counseling Center
2240 E. Buchtel Boulevard
Denver, CO 80208-3230
(303) 871-2205
insurance@hcc.du.edu

For questions about:

- Status of Claims
- Pharmacy Claim Forms
- Excluded Drugs

Please contact:

UnitedHealthcare **StudentResources**
P.O. Box 809025
Dallas, TX 75380-9025
1-866-648-8472

Important Phone Numbers

*For a life-threatening emergency call 911, or if on campus, call campus safety at (303)-871-3000.

Location

Health & Counseling Center
Daniel L. Ritchie Sports & Wellness Center,
3rd floor North
2240 East Buchtel Boulevard
Denver, CO 80208-3230

Health and Counseling www.du.edu/hcc

8:00am - 5:00pm, Mon., Wed., Thurs., Fri. and 9:00 am - 5:00 pm, Tues.

During the 2016-2017 Academic Year, the HCC will be open until 7:00 pm two nights a week during Fall, Winter, and Spring quarters.

(All year) except DU holidays and school closures.

Student Line: **(303) 871-2205**

Fax: **(303) 871-4242**

After hours: **(303) 871-2205**

Student Financial Services www.du.edu/bursar/

Bursar's Office

Student Line: **(303) 871-4944**

Fax: **(303) 871-4401**

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-866-648-8472 or visiting us at www.uhcsr.com/du.

Eligibility

All registered International students, scholars or other persons with a current passport and student visa engaged in educational activities at the University are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished.

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

How to Enroll

Students who meet eligibility requirements but are not enrolled in enough hours to be auto-assessed the premium on the student tuition bill or who are not considered traditional students by the University of Denver must contact the Health & Counseling Center during the indicated enrollment periods to purchase the Student Injury and Sickness Insurance Plan by submitting a completed Enrollment Form and premium payment.

Students enrolled in certificate or special programs, pursuing degrees in programs that are primarily online, or attending off-campus programs are not eligible for the Student Injury and Sickness Insurance Plan. The Health and Counseling Fee is mandatory for Undergraduate Students enrolled in six or more hours. Graduate Students may waive the Health and Counseling Fee each term. All students may waive the Student Injury and Sickness Insurance Plan during the fall and spring terms or academic year upon providing proof of adequate health insurance before the posted deadlines. **STUDENTS WHO FAIL TO WAIVE BY THE APPLICABLE WAIVER DEADLINE DATES WILL BE ENROLLED IN THE STUDENT INJURY AND SICKNESS INSURANCE PLAN.**

Enrollment/Waiver Deadlines

Quarter (Resident and Study Abroad) Students: Fall 09/30/16; *Winter 01/20/17;
Spring 04/14/17 *Summer: 07/7/17

Law Students: Fall 09/02/16, Spring 01/27/17, *Summer 06/16/17

***Winter and Summer enrollment periods are available to first time new DU students. Otherwise, enrollment in the Student Health Insurance Plan MUST be either Fall or Spring.**

****Study Abroad students are required to contact the DU HCC to discuss cost and enrollment, 303-871-2205. ** Otherwise, enrollment in the Student Health Insurance Plan MUST be either Fall or Spring.**

Effective and Termination Dates

The Master Policy becomes effective at 12:01 a.m., September 1, 2016. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 31, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

For Law Students Only: The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2016. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m. July 31, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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

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

Student Health Insurance Plan Coverage Periods

Rates Quarter Students (Resident and Study Abroad)	Fall 09/01/16 – 08/31/17	*Winter 01/03/17 – 03/26/17	Spring 03/27/17 – 08/31/17	*Summer 06/19/17 – 08/31/17
Student	\$1,330.00	\$665.00	\$1,330.00	\$665.00

Rates Semester Students (Law)	Fall 08/01/16 – 12/31/16	Spring 01/01/17 – 07/31/17	*Summer 05/30/17 – 07/31/17
Student	\$1,330.00	\$1,330.00	\$459.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

***Winter and Summer enrollment periods are available to first time new DU students. Otherwise, enrollment in the Student Health Insurance Plan MUST be either Fall or Spring.**

****Study Abroad students are required to contact the DU HCC to discuss cost and enrollment, 303-871-2205.**

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.

Health and Counseling Center (HCC) Referral Required

The student should use the services of the Health and Counseling Center first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Health and Counseling Center for which no prior approval or referral is obtained will be paid at the Out-of-Network level of benefits as specified in the Schedule of Benefits. A referral issued by the HCC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A HCC referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency.
2. When the HCC is closed.
3. Medical care received when the student is more than 50 miles from campus.
4. Medical care obtained when a student is no longer able to use the HCC due to a change in student status.
5. Maternity, obstetrical and gynecological care.

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 1-866-648-8472 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 1-866-648-8472 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 86.845%

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 Out-of-Network	\$500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Providers	80% except as noted below
Coinsurance Out-of-Network	60% except as noted below
Out-of-Pocket Maximum Preferred Providers	\$2,500 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network	\$7,500 (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.

If care is rendered outside of the United States, Covered Medical Expenses will be payable subject to all policy provisions, except that all charges will be reimbursed at 80% of Billed Charges after the Deductible of \$250 (Per Insured Person, Per Policy Year) has been met. After the Insured has paid \$7,500 for a covered Injury or Sickness, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year for that Injury or Sickness subject to any benefit maximums or limits that may apply.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the HCC. Per service copays apply to services rendered at the HCC listed in the following pages. For STD screening, not otherwise covered under Preventive Care, the physician office visit and laboratory tests are covered including a urinalysis and the comprehensive metabolic panel.

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 & 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:	50% of Preferred Allowance	50% of 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:	50% of Preferred Allowance	50% of Usual and Customary Charges
Anesthetist Services:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	100% of Preferred Allowance \$20 Copay per visit	Usual and Customary Charges \$20 Deductible per visit (The \$20 Deductible is in addition to the Policy Deductible.)
Physiotherapy: (Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.)	Preferred Allowance \$20 Copay per visit	Usual and Customary Charges \$20 Deductible per visit (The \$20 Deductible is in addition to the Policy Deductible.)
Medical Emergency Expenses: (Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.) (The Copay/per visit Deductible will be waived if admitted to the Hospital.)	Preferred Allowance \$150 Copay per visit	80% of Usual and Customary Charges \$150 Deductible per visit (The \$150 Deductible is in addition to the Policy Deductible.)
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

Outpatient	Preferred Provider	Out-of-Network
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges
Chemotherapy:	Preferred Allowance	Usual and Customary Charges
Prescription Drugs:	UnitedHealthcare Pharmacy (UHCP) \$15 Copay per prescription for Tier 1 \$30 Copay per prescription for Tier 2 up to a 31 day supply per prescription (Mail order Prescription Drugs through UHCP at 2 times the retail Copay up to a 90 day supply.)	No Benefits

Other	Preferred Provider	Out-of-Network
Ambulance Services:	Preferred Allowance	80% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees:	Preferred Allowance \$30 Copay per visit	Usual and Customary Charges \$30 Deductible per visit (In addition to the Policy Deductible)
Dental Treatment: (Benefits paid on Injury to Sound, Natural Teeth only.)	Preferred Allowance	80% of Usual and Customary Charges
Dental Treatment: (Benefits paid for removal of impacted wisdom teeth only.)	Preferred Allowance	80% of Usual and Customary Charges
Mental Illness Treatment: (See also Benefits for Biologically Based Mental Illness)	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment: (See also Benefits for Biologically Based Mental Illness)	Paid as any other Sickness	Paid as any other Sickness
Maternity:	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion:	Preferred Allowance	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.) (See also Benefits for Preventive Health Care) 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:	See Benefits for Diabetes	See Benefits for Diabetes
Home Health Care:	Preferred Allowance	Usual and Customary Charges
Hospice Care:	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility:	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility:	Preferred Allowance	Usual and Customary Charges
Urgent Care Center:	Preferred Allowance \$20 Copay per visit	Usual and Customary Charges \$20 Deductible per visit (The Deductible is in addition to the Policy Deductible.)
Hospital Outpatient Facility or Clinic:	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials:	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services:	Paid as any other Sickness	Paid as any other Sickness
TMJ Disorder:	Paid as any other Sickness	Paid as any other Sickness

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/du or call 1-855-828-7716 or the customer service number on your ID card 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.

Mail order Prescription Drugs are available at 2 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/du 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-2.
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:

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

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

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

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

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

Exceptions:

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

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

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

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

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

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

Network Pharmacy means a pharmacy that has:

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

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

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

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

Prescription Drug Cost means the rate the Company has agreed to pay the Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

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

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

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

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

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

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-866-648-8472. The Company will notify the Insured Person of the Company's determination within 72 hours.

Urgent Requests

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

External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-866-648-8472. The *Independent Review Organization (IRO)* will notify the Insured Person of the determination within 72 hours.

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-866-648-8472 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

Medical Expense Benefits – Injury and Sickness

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

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

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

Inpatient

1. Room and Board Expense.

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

2. Intensive Care.

If provided in the Schedule of Benefits.

3. Hospital Miscellaneous Expenses.

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

Benefits will be paid for services and supplies such as:

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

4. Routine Newborn Care.

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

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

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

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

5. Surgery (Inpatient).

Physician's fees for Inpatient surgery.

6. Assistant Surgeon Fees.

Assistant Surgeon fees in connection with Inpatient surgery.

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.

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. Repair is covered unless necessitated by misuse.
- Orthotic devices that straighten or change the shape of a body part.

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

27. Consultant Physician Fees.

Services provided on an Inpatient or outpatient basis.

28. Dental Treatment.

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

- Injury to Sound, Natural Teeth.
- Removal of impacted wisdom teeth.

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

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.

See also Benefits for Biologically Based Mental Illness.

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.

See also Benefits for Biologically Based Mental Illness.

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*.

See also Benefits for Preventive Health Care.

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.

See Benefits for Diabetes.

36. Home Health Care.

Services received from a licensed home health agency that are:

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

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

37. Hospice Care.

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

Hospice care includes:

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

38. Inpatient Rehabilitation Facility.

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

39. Skilled Nursing Facility.

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

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

40. Urgent Care Center.

Benefits are limited to:

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

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

41. Hospital Outpatient Facility or Clinic.

Benefits are limited to:

- The facility or clinic fee billed by the Hospital.

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

42. Approved Clinical Trials.

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

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include:

- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- Federally funded trials that meet required conditions.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

43. Transplantation Services.

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

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

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

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

44. TMJ Disorder.

Same as any other Sickness and limited to the following services only:

- Diagnostic X-ray Services.
- Laboratory procedures.
- Physical therapy.
- Surgery.

Mandated Benefits

BENEFITS FOR TELEMEDICINE SERVICES

Benefits will be paid for Covered Medical Expenses on the same basis as services provided through a face-to-face consultation for services provided through Telemedicine for an Insured residing in a county with one hundred fifty thousand or fewer residents. "Telemedicine" means the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education. The term does not include services performed using a telephone or facsimile machine.

Nothing in this provision shall require the use of Telemedicine when in-person care by a participating provider is available to an Insured Person within the Company's network and within the Insured's geographic area.

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid for actual charges incurred for an annual screening by a Physician for the early detection of prostate cancer. Benefits will be payable for one screening per year for any male Insured 50 years of age or older. One screening per year shall be covered for any male Insured 40 to 50 years of age who is at risk of developing prostate cancer as determined by the Insured's Physician. The screening shall consist of the following tests:

- 1) A prostate-specific antigen (PSA) blood test; and
- 2) Digital rectal examination.

The policy Deductible will not be applied to this benefit and this benefit will not reduce any diagnostic benefits otherwise allowable under the policy.

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

BENEFITS FOR BIOLOGICALLY BASED MENTAL ILLNESS

Benefits will be paid the same as any other Sickness for the treatment of Biologically Based Mental Illness and Mental Disorders as defined below. The benefit provided will not duplicate any other benefits provided in this policy.

“Biologically Based Mental Illness” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

“Mental Disorder” means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. Mental Disorder also includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient, day treatment, and in-patient basis, exclusive of residential treatment.

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

BENEFITS FOR DIABETES

Benefits will be paid for the Usual and Customary Charges for all medically appropriate and necessary equipment, supplies, and outpatient diabetes self-management training and educational services including nutritional therapy if prescribed by a Physician.

Diabetes outpatient self-management training and education shall be provided by a Physician with expertise in diabetes.

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

BENEFITS FOR CERVICAL CANCER VACCINES

Benefits are payable for the cost of cervical cancer vaccinations for all female Insured Persons for whom a vaccination is recommended by the Advisory Committee on Immunization practices of the United States Department of Health and Human Services.

BENEFITS FOR MEDICAL FOODS

Benefits are payable for Medical Foods needed to treat inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as specified below.

If the policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Sickness for Medical Foods, to the extent Medically Necessary, for home use for which a Physician has issued a written, oral or electronic prescription. Benefits will not be provided for alternative medicine.

Coverage includes but is not limited to the following diagnosed conditions: phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Benefits do not apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

There is no age limit on the benefits provided for inherited enzymatic disorders except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

Medical foods means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy that are specifically designed and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a Physician.

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

BENEFITS FOR CLEFT LIP OR CLEFT PALATE

Benefits will be paid the same as any other Sickness for treatment of newborn children born with cleft lip or cleft palate or both. Benefits shall include the Medically Necessary care and treatment including oral and facial surgery; surgical management; the Medically Necessary care by a plastic or oral surgeon; prosthetic treatment such as obturators, speech appliances, feeding appliances; Medically Necessary orthodontic and prosthodontic treatment; habilitative speech therapy, otolaryngology treatment; and audiological assessments and treatment.

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

BENEFITS FOR HEARING AIDS FOR MINOR CHILDREN

Benefits will be paid for Covered Medical Expenses for Hearing Aids for a Minor Child who has a hearing loss that has been verified by a licensed Physician and a licensed Audiologist. The Hearing Aid shall be medically appropriate to meet the needs of the Minor Child according to accepted professional standards.

Benefits shall include the purchase of the following:

- 1) Initial Hearing Aids and replacement Hearing Aids not more frequently than every five years;
- 2) A new Hearing Aid when alterations to the existing Hearing Aid cannot adequately meet the needs of the Minor Child; and
- 3) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to professional standards.

“Hearing Aid” means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. “Hearing Aid” shall include any parts or ear molds.

“Minor Child” means an Insured Person under the age of eighteen.

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

BENEFITS FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Sickness for Covered Medical Expenses related to the assessment, diagnosis and treatment, including Applied Behavior Analysis, of Autism Spectrum Disorders. Treatment for Autism Spectrum Disorders must be prescribed or ordered by a licensed Physician or license psychologist.

“Applied behavior analysis” means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

“Autism Spectrum Disorders” include the following neurobiological disorders: autistic disorder, asperger’s disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time of diagnosis.

“Treatment for Autism Spectrum Disorders” shall be for treatments that are Medically Necessary, appropriate, effective, or efficient. Treatment for Autism Spectrum Disorders shall include:

- 1) Evaluation and assessment services;
- 2) Behavior training and behavior management and applied behavior analysis, including but not limited to, consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers;
- 3) Habilitative or rehabilitative care, including but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies;
- 4) Psychiatric care;
- 5) Psychological care, including family counseling;
- 6) Therapeutic care; and
- 7) Pharmacy care and medication if provided for in the policy.

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

BENEFITS FOR PREVENTIVE HEALTH CARE

Benefits will be provided for the cost of the following Preventive Health Care services, in accordance with the A or B Recommendations of the Task Force for the particular Preventive Health Care service:

- 1) Alcohol misuse screening and behavioral counseling interventions for adults by their Physician;
- 2) Cervical Cancer Screening;
- 3) Breast Cancer Screening with Mammography:
 - a) Benefits shall be determined on a Policy Year basis and shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy;
 - b) If an Insured Person who is eligible for a preventive mammography screening has not utilized the benefit during the Policy Year, then the coverage shall apply to one diagnostic screening for that same Policy Year. Any other diagnostic screenings shall be subject to all applicable policy provisions;
 - c) Benefits shall also be provided for an annual breast cancer screening with mammography for an Insured Person possessing at least one risk factor including, but not limited to, a family history of breast cancer, being forty years of age or older, or a genetic predisposition to breast cancer;
- 2) Cholesterol screening for lipid disorders;
- 3) Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps. Benefits shall also be provided to an Insured Person who is at a high risk for colorectal cancer, including an Insured Person who has a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by a Physician;
- 4) Child health supervision services and childhood immunizations pursuant to the schedule established by the ACIP;
- 5) Influenza vaccinations pursuant to the schedule established by the ACIP;
- 6) Pneumococcal vaccinations pursuant to the schedule established by the ACIP; and
- 7) Tobacco use screening of adults and tobacco cessation interventions by the Insured Person's Physician.
- 8) Any other preventive services included in the A or B Recommendation of the Task Force or required by federal law.

"ACIP" means the advisory committee on immunization practices to the centers for disease control and prevention in the federal Department of Health and Human Services, or any successor entity.

"A Recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit of the preventive health care service is substantial.

"B Recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

"Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal Department of Health and Human Services.

The policy Deductible, Copays and Coinsurance will not be applied to this benefit.
Benefits shall be subject to all other limitations or any other provisions of the policy.

BENEFITS FOR ORAL ANTICANCER MEDICATION

Benefits will be provided for prescribed, orally administered anticancer medication that has been approved by the Federal Food and Drug Administration and is used to kill or slow the growth of cancerous cells.

The orally administered medication shall be provided at a cost to the Insured not to exceed the Coinsurance percentage or the Copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose.

The medication provided pursuant to this benefit shall:

- 1) only be prescribed upon a finding that it is Medically Necessary by the treating Physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice;
- 2) be clinically appropriate in terms of type, frequency, extent site, and duration; and
- 3) not be primarily for the convenience of the Insured or Physician.

This benefit does not require the use of orally administered medications as a replacement for other cancer medications, nor does it prohibit the Company from applying an appropriate formulary or other clinical management to any medication described in this benefit.

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

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

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

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

HOSPITAL means a health institution planned, organized, operated, and maintained to offer facilities, beds, and services over a continuous period exceeding twenty four (24) hours to individuals requiring diagnosis and treatment for illness, Injury, deformity, abnormality, or pregnancy. Clinical laboratory, diagnostic X-ray, and definitive medical treatment under an organized medical staff shall be provided within the institution. Treatment facilities for emergency and surgical services shall be provided either within the institution or by contractual agreement for those services with another licensed Hospital. Services provided by contractual agreement shall be documented by a well-defined plan for the provision of contracted services, related to community needs. Definitive medical treatment may include obstetrics, pediatrics, psychiatry, physical medicine and rehabilitation, X-ray therapy, and similar specialized treatment.

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: the Named Insured. 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*. Mental Illness does not mean a Biologically Based Mental Illness or a Mental Disorder as defined in the Benefits for Biologically Based Mental Illness. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

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

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. 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.

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*. Substance use disorder does not mean a Mental Disorder as defined in the Benefits for Biologically Based Mental Illness. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

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

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

Exclusions and Limitations

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

1. Acupuncture.
2. Developmental delay or disorder or mental retardation. Learning disabilities.

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.
 - Treat or correct Congenital Conditions of a Newborn 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 specifically provided in the Schedule of Benefits.

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:
 - Supportive devices for the foot.

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
9. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:

 - Hearing defects or hearing loss as a result of an infection or Injury.
 - Hearing Aids specifically provided for in Benefits for Hearing Aids for Minor Children.
 - Hearing exams and tests to determine the need for hearing correction.
10. Hirsutism. Alopecia.
11. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
13. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
14. Injury sustained while:
 - Participating in any intercollegiate or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
15. Investigational services.
16. Lipectomy.
17. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
18. 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.
 - 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.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
19. Reproductive/Infertility services including but not limited to the following:
 - Genetic counseling and genetic testing.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Reversal of sterilization procedures.
 - Sexual reassignment surgery.
20. 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.
21. Residential treatment of eating disorders, such as anorexia or bulimia.

22. 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.
23. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
24. 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.
25. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
26. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
27. Speech therapy, except as specifically provided in the policy.
28. 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.
29. Supplies, except as specifically provided in the policy.
30. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
31. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
32. War or any act of war, declared or undeclared; or while in the armed forces of any country other than the United States (a pro-rata premium will be refunded upon request for such period not covered).
33. Weight management. Weight reduction programs. Weight management programs. Treatment for 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 are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

International students: you are eligible to receive UnitedHealthcare Global services worldwide, except in your home country.

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

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to \$5,000.00 payment
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral

- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit www.uhcsr.com/UHGlobal 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@UHGlobal.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
- 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; 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 Health and Counseling Center (HCC) or Infirmary for treatment or referral, or when the HCC is closed, 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 12months.	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) Benefit includes all adjustments within 6 months of installation.	50%	50%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50%	50%
Endodontics (Root Canal Therapy)	50%	50%
Periodontal Surgery (Gum Surgery) Limited to 1 quadrant or site per 36 months per surgical area.	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.	50%	50%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50%	50%
Oral Surgery, including Surgical Extraction	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services		
<p>General Services (including Dental Emergency treatment)</p> <p>Covered as a separate benefit only if no other service was done during the visit other than X-rays.</p> <p>General anesthesia is covered when clinically necessary.</p> <p>Occlusal guards limited to 1 guard every 12 months.</p>	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.		
<p>Inlays/Onlays/Crowns (Partial to Full Crowns)</p> <p>Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.</p>	50%	50%
<p>Fixed Prosthetics (Bridges)</p> <p>Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.</p>	50%	50%
<p>Removable Prosthetics (Full or partial dentures)</p> <p>Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.</p>	50%	50%
<p>Relining and Rebased Dentures</p> <p>Limited to relining/rebased performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.</p>	50%	50%
<p>Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns</p> <p>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.</p>	50%	50%
Implants		
<p>Implant Placement</p> <p>Limited to 1 time per 60 months.</p>	50%	50%
<p>Implant Supported Prosthetics</p> <p>Limited to 1 time per 60 months.</p>	50%	50%
<p>Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis.</p> <p>Limited to 1 time per 60 months.</p>	50%	50%
<p>Repair Implant Supported Prosthesis by Report</p> <p>Limited to 1 time per 60 months.</p>	50%	50%
<p>Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium</p> <p>Limited to 1 time per 60 months.</p>	50%	50%
<p>Repair Implant Abutment by Support</p> <p>Limited to 1 time per 60 months.</p>	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.
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. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

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

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

Claim Forms

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

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

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

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

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year 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.		
<ul style="list-style-type: none"> • Single Vision 		100% after a Copayment of \$40.	50% of the billed charge.
<ul style="list-style-type: none"> • Bifocal 		100% after a Copayment of \$40.	50% of the billed charge.
<ul style="list-style-type: none"> • Trifocal 		100% after a Copayment of \$40.	50% of the billed charge.
<ul style="list-style-type: none"> • Lenticular 		100% after a Copayment of \$40.	50% of the billed charge.
Lens Extras	Once per year.		
<ul style="list-style-type: none"> • Polycarbonate Lenses 		100%	100% of the billed charge.
<ul style="list-style-type: none"> • Standard scratch-resistant coating 		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
<ul style="list-style-type: none"> • Eyeglass frames with a retail cost up to \$130. 		100%	50% of the billed charge.
<ul style="list-style-type: none"> • Eyeglass frames with a retail cost of \$130 - 160. 		100% after a Copayment of \$15.	50% of the billed charge.
<ul style="list-style-type: none"> • Eyeglass frames with a retail cost of \$160 - 200. 		100% after a Copayment of \$30.	50% of the billed charge.
<ul style="list-style-type: none"> • Eyeglass frames with a retail cost of \$200 - 250. 		100% after a Copayment of \$50.	50% of the billed charge.
<ul style="list-style-type: none"> • Eyeglass frames with a retail cost greater than \$250. 		60%	50% of the billed charge.
Contact Lenses	Limited to a 12 month supply.		
<ul style="list-style-type: none"> • Covered Contact Lens Selection 		100% after a Copayment of \$40.	50% of the billed charge.
<ul style="list-style-type: none"> • Necessary Contact Lenses 		100% after a Copayment of \$40.	50% of the billed charge.
<p>Low Vision Services</p> <p>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.</p>	Once every 24 months.		
<ul style="list-style-type: none"> • Low Vision Testing 		100% of the billed charge.	75% of the billed charge.
<ul style="list-style-type: none"> • Low Vision Therapy 		100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060

Reimbursement for Low Vision Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year 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 Designated Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination. In order to secure an Internal Review after the receipt of the notification of a benefit denied due to a contractual exclusion, the Insured Person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the policy exclusion does not apply to the denied benefit.

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 1-866-648-8472 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 or a Designated Representative may submit a request, either orally or in writing, for an Expedited Internal Appeal (EIR) of an Adverse Determination:

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

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or a Designated Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Designated Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Insured Person has been notified of the final determination.

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

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

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 Designated 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, or the treatment is determined to be experimental or investigational.

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 Designated Representative has received an Adverse Determination, and
 - a. The Insured Person, or the Insured Person's Designated 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 Designated 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.

The Insured Person or Insured Person's Designated Representative's request for an Expedited External Review must include a Physician's Certification that the Insured Person's medical condition meets the above criteria.

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

Where to Send External Review Requests

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

Claims Appeals
UnitedHealthcare **Student**Resources
PO Box 809025
Dallas, TX 75380-9025
888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service at 1-866-648-8472 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Submit all Claims or Inquiries to:

UnitedHealthcare **StudentResources**
P.O. Box 809025
Dallas, Texas 75380-9025
1-866-648-8472

Please keep this Brochure 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 Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

This Brochure is based on Policy # 2016-5893-4.



POLICY NUMBER: 2016-5893-4

NOTICE:

The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC1 - 11/16/2016

NOC#1 11/16/2016

Policy:

Added below wording to SHC paragraph on SOB header:

For STD screening, not otherwise covered under Preventive Care, the physician office visit and laboratory tests are covered including a urinalysis and the comprehensive metabolic panel.

Brochure:

Added below wording to SHC paragraph on SOB header:

For STD screening, not otherwise covered under Preventive Care, the physician office visit and laboratory tests are covered including a urinalysis and the comprehensive metabolic panel.

Summary Brochure:

N/A