UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT INJURY AND SICKNESS INSURANCE PLAN
NON-RENEWABLE ONE YEAR TERM INSURANCE
BLANKET ACCIDENT AND HEALTH COVERAGE
CERTIFICATE OF COVERAGE

Designed Especially for the Students of

PFEIFFER UNIVERSITY

PLEASE NOTE:

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

2017-2018

This Certificate of Coverage is Part of Policy # 2017-939-61

This Certificate of Coverage ("Certificate") is part of the contract between UnitedHealthcare Insurance Company (hereinafter referred to as the "Company") and the Policyholder.

Please keep this Certificate as an explanation of the benefits available to the Insured Person under the contract between the Company and the Policyholder. This Certificate is not a contract between the Insured Person and the Company. Amendments or endorsements may be delivered with the Certificate or added thereafter. The Master Policy is on file with the Policyholder and contains all of the provisions, limitations, exclusions, and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS THE INSURED PERSON'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

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Important Cancellation Information – Please read the provisions entitled, "Effective and Termination Date" found on page 2.

Introduction

Welcome to the UnitedHealthcare StudentResources Student Injury and Sickness Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance Company ("the Company").

The school (referred to as the "Policyholder") has purchased a Policy from the Company. The Company will provide the benefits described in this Certificate to Insured Persons, as defined in the Definitions section of this Certificate. This Certificate is not a contract between the Insured Person and the Company. Keep this Certificate with other important papers so that it is available for future reference.

This plan is a preferred provider organization or "PPO" plan. It provides a higher level of coverage when Covered Medical Expenses are received from healthcare providers who are part of the plan's network of "Preferred Providers." The plan also provides coverage when Covered Medical Expenses are obtained from healthcare providers who are not Preferred Providers, known as "Out-of-Network Providers." However, a lower level of coverage may be provided when care is received from Out-of-Network Providers and the Insured Person may be responsible for paying a greater portion of the cost.

To receive the highest level of benefits from the plan, the Insured Person should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the plan's web site at www.firststudent.com. The web site will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at 1-800-505-4160, toll free, for assistance in finding a Preferred Provider.

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-800-505-4160. The Insured can also write to the Company at:

FirstStudent
P.O. Box 809025
Dallas, TX 75380-9025

Section 1: Who Is Covered

The Master Policy covers students and their eligible Dependents who have met the Policy's eligibility requirements (as shown below) and who:

1. Are properly enrolled in the plan, and
2. Pay the required premium.

All full-time undergraduate students taking 12 or more credit hours are automatically enrolled in this insurance Plan at registration unless proof of comparable coverage is furnished. All international students are automatically enrolled in this insurance plan at registration.

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

The student (Named Insured, as defined this Certificate) 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 and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:

a. On the date the Named Insured acquires a legal spouse or a Domestic Partner who meets the specific requirements set forth in the Definitions section of this Certificate.
b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.
c. On the date the Named Insured is required by court or administrative order to provide health coverage of a dependent child without regard to any enrollment season restrictions.

Dependent eligibility expires concurrently with that of the Named Insured.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2017. The Insured Person'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, 2018. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

The Insured Person must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Insured Person's premium must be received within 31 days after the coverage expiration date. It is the Insured Person's responsibility to make timely premium payments to avoid a lapse in coverage.

There is no pro-rata or reduced premium payment for late enrollees. Refunds of premiums are allowed only upon entry into the armed forces.

The Master Policy is a non-renewable one year term insurance policy. The Master Policy will not be renewed.

Section 3: 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 12 months 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.

Section 4: 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. A list of Preferred Providers is located on the plan's web site at www.firststudent.com. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-505-4160 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.

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

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

Inpatient Expenses

Preferred Providers – Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-800-505-4160 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 or Physician groups 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.

Out-of-Network Medical Emergency Services

When Emergency Services for an Emergency Medical Condition are provided by an Out-of-Network Provider, benefits will be based on the lesser of an amount negotiated with the Out-of-Network Provider or the billed amount. Benefits will be subject to the same Deductible, Copay or Coinsurance amounts that are applicable to Medical Emergency Services provided by a Preferred Provider.

Example of Determination of Payment Obligations:

Preferred Provider Benefits

Preferred Provider Coinsurance percentage applied to the Preferred Allowance

For example, if the policy pays 90% of Preferred Allowance and the Preferred Allowance is $100; the Company's benefit payment would be 90% x $100 = $90.

The Company would pay $90 and the Insured would be responsible for payment to the Preferred Provider of $10. The billed amount less the Preferred Allowance is an ineligible amount not owed to the Preferred Provider in accordance with an agreement between the Company and provider.

Out-of-Network Benefits

Out-of-Network Coinsurance percentage applied to the Usual and Customary Charge

For example, if the Policy pays 80% of Usual and Customary and the Usual and Customary Charge is $100, the Company's benefit payment would be 80% x $100 = $80.

The Company would pay $80 and the Insured would be responsible for payment to the provider of the billed amount less the amount the Company paid.

NOTICE: The Insured's actual costs for Covered Medical Expenses may exceed the stated Coinsurance or Copayment amount because actual provider charges may not be used to determine Policy and Insured payment obligations.

Section 5: Medical Expense Benefits – Injury and Sickness

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

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

ESSENTIAL HEALTH BENEFITS: The following benefits are considered Essential Health Benefits.

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**.
   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**.
Non-surgical Physician services when confined as an Inpatient.

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**.
Physician's fees for outpatient surgery.

12. **Day Surgery Miscellaneous**.
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**.
Assistant Surgeon Fees in connection with outpatient surgery.

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

15. **Physician's Visits**.
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**.
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: a) the restoration of speech impaired by Sickness, surgery, or Injury; b) certain significant physical Congenital Conditions such as cleft lip and palate; or c) swallowing disorders related to a specific Sickness or Injury. Benefits do not include speech therapy for stammering or stuttering.

17. **Medical Emergency Expenses**.
Benefits will be paid for Emergency Services in connection with an Emergency Medical Condition, as defined.

18. **Diagnostic X-ray Services.**
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.**
See Schedule of Benefits.

20. **Laboratory Procedures.**
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.**
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.
- Dialysis and hemodialysis.

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

22. **Injections**.
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**.
See Schedule of Benefits.

24. **Prescription Drugs**.
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.
- Orthotic devices that straighten or change the shape of a body part, including foot orthotics custom molded to the Insured. This does not include pre-molded foot orthotics or over-the-counter supportive devices.
- Orthotic devices for the correction of positional plagiocephaly, including dynamic cranioplasty (DOC) bands and soft helmets.

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

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

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Natural Teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

Any dental treatment limitations do not apply to pediatric dental care covered under the Pediatric Dental Services benefits. 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.

30. **Substance Use Disorder Treatment.**
See Benefits for Treatment for Chemical Dependency.

31. **Maternity.**
Same as any other Sickness.

See Benefits for Maternity Expenses.

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

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

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

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

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

36. **Home Health Care**.
Services for private duty services must be provided on a part-time or intermittent schedule when skilled nursing care is required and received from a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) and/or other skilled care services like Physiotherapy for short-term rehabilitation therapies. Services from a home health aide are covered only when the care provided supports a skilled service being delivered in the home.

Home health care services must be:
- Medically Necessary.
- Ordered by the Insured's Physician.
- Provided when the Insured Person is homebound due to an Injury or Sickness.

Usually, a home health agency coordinates the services ordered by the Insured's Physician.

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.**
See Benefits for Covered Clinical Trials.

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. Benefits are also available for reasonable and necessary services related to the search for a donor.

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 the 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 the 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 and lodging expenses may be reimbursed based on the Company's guidelines that are available upon request from customer service. 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. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the attached Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits endorsements.

45. Infertility Services.
Benefits are payable for certain services related to the diagnosis, treatment and correction of any underlying causes of Infertility for all Insured Persons except for Dependent children.

Benefits are not available for the following:
- Artificial means of conception, including, but not limited to, artificial insemination, in-vitro fertilization (IVF), ovum or embryo Placement, intracytoplasmic sperm injection (ICSI), and gamete intrafallopian transfer (GIFT) and associated services.
- Donor eggs and sperm.
- Surrogate mothers

Infertility means the inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.

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

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

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

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

48. Sexual Dysfunction.
Benefits are available for certain services related to the diagnosis, treatment and correction of any underlying causes of sexual dysfunction for Insureds. Benefits for Sexual Dysfunction unrelated to organic disease are not covered.

49. **Sterilization.**
Benefits are limited to:
- Tubal ligation not covered under the Preventive Care Services benefit.
- Male vasectomy.

50. **Nutritional Counseling.**
Benefits are provided for Covered Medical Expenses incurred for Medically Necessary nutritional counseling services due to a Sickness or Injury.

Section 6: Mandated Benefits

BENEFITS FOR EMERGENCY SERVICES

Benefits will be paid the same as any other Sickness or Injury for treatment of a Medical Emergency. The Insured should use emergency services, including calling 911 or other telephone access systems utilized to access pre hospital emergency services when appropriate for treatment of a Medical Emergency.

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

BENEFITS FOR TREATMENT OF BONES AND JOINTS OF THE JAW, FACE OR HEAD

Benefits will be paid for the diagnosis, therapeutic, and surgical procedures involving bones or joints of the jaw, face, or head on the same basis as for procedures involving other bones or joints of the human skeletal structure. The procedures must be Medically Necessary to treat a condition which prevents normal functioning of that particular bone or joint involved and the condition is caused by congenital deformity, Sickness or traumatic Injury.

Procedures for the treatment of conditions of the jaw (temporomandibular joint) will include splinting and use of intraoral prosthetic appliances to reposition the bones. No benefits will be paid for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, root canal or routine dental treatment.

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

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY FOLLOWING MASTECTOMY

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery following a Mastectomy. Benefits will be paid for all stages and revisions of Reconstructive Breast Surgery performed on a diseased breast, as well as for prostheses and physical complications in all stages of Mastectomy, including lymphedemas. Reconstruction of the nipple/areolar complex following a Mastectomy is covered without regard to the lapse of time between the Mastectomy and the reconstruction upon approval by the treating Physician.

“Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

“Reconstructive breast surgery” means surgery performed as a result of a Mastectomy to re-establish symmetry between the two breasts, and includes reconstruction of the Mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. “Reconstructive breast surgery” also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

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

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for Medically Necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures, used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician or healthcare professional designated by the Physician.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, Insured's with serious mental or physical conditions, and Insured's with significant behavioral problems, where the Physician treating the Insured involved certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

Benefits do not include expenses for dental procedures except as specifically provided in the Schedule of Benefits.

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

BENEFITS FOR THE TREATMENT OF LYMPHEDEMA

Benefits will be paid the same as any other Sickness for the diagnosis, evaluation, and treatment of lymphedema including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a Physician.

Gradient Compression Garments:

1. Require a prescription;
2. Are custom-fit for the Insured Person; and
3. Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

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

BENEFITS FOR HEARING AIDS

Benefits will be paid for one hearing aid per hearing-impaired ear every 36 months for Insureds under 22 years of age when Medically Necessary and ordered by a Physician or audiologist licensed in the state. Coverage includes:

1. Initial hearing aids and replacement hearing aids not more frequently than every 36 months.
2. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Insured Person.
3. Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

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

BENEFITS FOR COVERED CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for participation in phase I, phase II, phase III, and phase IV Covered Clinical Trials by an Insured who meets protocol requirements of the trials and when informed consent is provided.

Only Covered Medical Expenses for the costs of health care services which are a Medical Necessity and associated with participation in a Covered Clinical Trial, including those related health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and Medically Necessary monitoring will be paid and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

No benefits will be provided for non-FDA approved drugs provided or made available to an Insured patient who received the drug during a Covered Clinical Trial after the clinical trial has been discontinued.

The following clinical trial costs are not covered:

1. Costs of services that are not health care services;
2. Cost of services provided solely to satisfy data collection and analysis needs;
3. Costs of services related to investigation drugs and devices; and
4. Costs of services that are not provided for the direct clinical management of the Insured patient.

"Covered Clinical Trials" means phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:

1. Involve the treatment of life-threatening medical conditions;
2. Are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives;
3. Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives;
4. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
5. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and
6. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

In the event a claim contains charges related to services for which coverage is required under this benefit, and those charges cannot be separated from costs related to services that are not covered under this benefit, the Company shall deny the claim.

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

BENEFITS FOR MATERNITY EXPENSES

Benefits will be paid the same as any other Sickness for Inpatient and outpatient maternity care.

Inpatient benefits will include:

1. A minimum of forty-eight (48) hours of inpatient care following a vaginal delivery for the mother and her Newborn Infant after childbirth; and
2. A minimum of ninety-six (96) hours of inpatient care following a cesarean section for the mother and Newborn Infant after childbirth.

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. In the case of a decision to discharge the mother and her Newborn Infant from the Inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, benefits will include Timely Postdelivery Care. Timely Postdelivery Care shall be provided to a mother and her Newborn Infant by a registered nurse, Physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health. Such follow-up care shall be provided in:

1. The home, a provider's office, a Hospital, a birthing center, an immediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or
2. Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

"Timely PostDelivery Care" means health care that is provided:

1. Following the discharge of a mother and her Newborn Infant from the Inpatient setting; and
2. In a manner that meets the health care needs of the mother and her Newborn Infant, which provides for the appropriate monitoring of the conditions of the mother and Newborn Infant, and occurs not later than the 72-hour period immediately following discharge.

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

BENEFITS FOR TREATMENT FOR CHEMICAL DEPENDENCY

Benefits will be paid the same as any other Sickness for treatment of Chemical Dependency.

Benefits will be paid for the necessary care and treatment of Chemical Dependency for services received from any of the following providers:

1. The following units of a Hospital licensed under Article 5 of General Statutes Chapter 131E:

    a. Chemical Dependency units in facilities licensed after October 1, 1984;
    b. Medical units;
    c. Psychiatric units; and

2. The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:

    a. Chemical Dependency units in psychiatric hospitals;
    b. Chemical Dependency Hospitals;
    c. Residential Chemical Dependency treatment facilities;
    d. Social setting detoxification facilities or programs;
    e. Medical detoxification or programs; and

3. Duly licensed Physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such Physicians or psychologists in facilities described in 1) and 2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984 under Article 2 of General Statutes Chapter 122C.

The term “Chemical Dependency” means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

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

Preventive Care Services

The following state mandated benefits are also federally required Preventive Care Services.

BENEFITS FOR CERVICAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for Examinations and Laboratory Tests for the screening for the early detection of cervical cancer. Benefits shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control and will include the examination, laboratory fee, and the Physician's interpretation of the laboratory results.

Reimbursement for the laboratory fee will be made only if the laboratory meets accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

“Examinations and laboratory tests” means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

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

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Sickness for Low-dose Screening Mammography according to the following guidelines:

1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this benefit, "at risk" means the following:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30.
2. One baseline mammogram for any woman thirty-five through thirty-nine years of age, inclusive.
3. A mammogram every other year for any woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Physician.
4. A mammogram every year for any woman fifty years of age or older.

Reimbursement will be made only if the facility where treatment is rendered meets the mammography accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a Physician's interpretation of the results of the procedure.

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

BENEFITS FOR SURVEILLANCE TESTS FOR WOMEN AT RISK FOR OVARIAN CANCER

Benefits will be paid the same as any other Sickness for Surveillance Tests for women age 25 and older At Risk for Ovarian Cancer.

“At risk for ovarian cancer” means either: a) having a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or 2) testing positive for a hereditary ovarian cancer syndrome.

“Surveillance tests” mean annual screening using: a) transvaginal ultrasound, and 2) rectovaginal pelvic examination.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for Colorectal Cancer Screening. Beginning at age 50, benefits will be provided for non-symptomatic Insured Persons for one of the five screening options below:

1. Yearly fecal occult blood test (FOBT); or
2. Flexible sigmoidoscopy every five (5) years; or
3. Yearly fecal occult blood test plus flexible sigmoidoscopy every five (5) years; or
4. Double contrast barium enema every five (5) years; or
5. Colonoscopy every ten (10) years.

In addition, upon recommendation of the Physician, Medically Necessary benefits will be provided for one or more of the screening options, based on American Cancer Society guidelines regarding family history or other factors, regardless of the age of the Insured.

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

BENEFITS FOR PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) or equivalent tests for the presence of prostate cancer when recommended by a Physician.

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

BENEFITS FOR BONE MASS MEASUREMENT

Benefits will be paid the same as any other Sickness for a Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass for Qualified Individuals.

Benefits will be paid for one Bone Mass Measurement every 23 months. Benefits will be paid more frequently when Medically Necessary. Conditions that may be considered Medically Necessary include, but are not limited to: 1) monitoring beneficiaries on long-term glucocorticoid therapy of more than three months and 2) to determine the effectiveness of adding an additional treatment regimen for a Qualified Individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

"Bone mass measurement" means a scientifically proven radiologic, radioisotopic, or other procedure performed on a Qualified Individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

"Qualified individual" means any one or more of the following:

1. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
2. An individual with radiographic osteopenia anywhere in the skeleton;
3. An individual who is receiving long-term glucocorticoid (steroid) therapy;
4. An individual who primary hyperparathyroidism;
5. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
6. An individual who has a history of low-trauma fractures; or
7. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

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

BENEFITS FOR PRESCRIPTION CONTRACEPTIVES

Benefits will be paid the same as any other prescription drug or device for any contraceptive drug or device including the insertion or removal and any medical examination associated with the use of such contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid the same as any other Sickness for outpatient contraceptive services provided by a Physician.

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

BENEFITS FOR NEWBORN HEARING SCREENING

Benefits will be paid the same as any other Sickness for Physician ordered newborn hearing screening.

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

Section 7: 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	$5,000
Two or More Members	$5,000
One Member	$2,500
Thumb or Index Finger	$1,250

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.

The Accidental Death benefit is payable for the involuntary inhalation of gas and fumes and the involuntary taking of poison.

Section 8: 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 the Policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

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

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

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

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

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

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

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 MEDICAL CONDITION means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention would result in any of the following:

1. Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any body organ or part.

EMERGENCY SERVICES means health care items and services furnished or required to screen for or treat an Emergency Medical Condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

ESSENTIAL HEALTH BENEFITS means the following general categories and the items and services covered within the categories:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

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

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

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

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home. Hospital includes a duly licensed state tax-supported institution as defined in Statute 58-51-40 of the North Carolina Insurance Code.

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 the 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 the Policy's Effective Date will be considered a Sickness under the Policy.

IN-NETWORK COVERED MEDICAL EXPENSES means Covered Medical Expenses that are received under the terms of the Policy from providers under contract with or approved in advance by the Company and means Medical Emergency services regardless of the status or affiliation of the provider of such services.

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 the Policy.

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

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

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

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

MEDICAL NECESSITY/MEDICALLY NECESSARY means those services or supplies that are all of the following:

1. Provided for the diagnosis, treatment, cure, or relief of a health condition, Sickness, Injury, or disease and not for experimental, investigational, or cosmetic purposes, except as allowed for covered clinical trials.
2. Necessary for and appropriate to the diagnosis, treatment, cure, or relieve of the health condition, Sickness, Injury, disease or its symptoms.
3. Within generally accepted standards of medical care in the community.
4. Not solely for the convenience of the Insured, the Insured's family, or the provider.
5. The most appropriate supply or level of service which can safely be provided to the Insured.

For Medically Necessary services, the Company may compare the cost effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

MENTAL ILLNESS means a Sickness that is a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent edition, substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.* 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 Policy; and 2) the appropriate premium for coverage has been paid.

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.

NEWBORN INFANT, ADOPTED OR FOSTER CHILD means any child born of an Insured or placed with an Insured while that person is insured under the Policy. Such child will be covered under the policy from the moment of birth or placement for the first 31 days after birth or placement. 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, or birth abnormalities including treatment of cleft lip and cleft palate, prematurity and nursery care.

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

If family coverage is in force and no additional premium is required, enrollment/notification of the new Dependent within the specified period of time will not be required nor penalties applied for failure to do so.

OUT-OF-NETWORK COVERED MEDICAL EXPENSES means non-emergency Covered Medical Expenses that are not received according to the terms of the Policy including services from affiliated providers that are received without the approval of the Company.

OUT-OF-NETWORK PROVIDER means a health care provider who has not agreed to accept special reimbursement or other terms for health care services from the Company for health care services on a fee-for-service basis.

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 OR MASTER POLICY means the entire agreement issued to the Policyholder that includes all of the following:

1. The Policy.
2. The Policyholder Application.
3. The Certificate of Coverage.
4. The Schedule of Benefits.
5. Endorsements.
6. Amendments.

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

POLICYHOLDER means the institution of higher education to whom the Master Policy is issued.

PREFERRED PROVIDER means a health care provider who has agreed to accept special reimbursement or other terms for health care services from the Company for health care services on a fee-for-service basis.

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, illness or disease of the Insured Person which causes loss while the Insured Person is covered under the 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 the Policy's Effective Date will be considered a sickness under the Policy.

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

SUBSTANCE USE DISORDER means a Sickness caused by a Chemical Dependency which is the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

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 maximum amount the Policy is obligated to pay for services. Except as otherwise required under state or federal regulations, usual and customary charges will be the lowest of:

1. The billed charge for the services.
2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered.
3. An amount determined using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical difference where applicable, plus a margin factor.

The Company uses data from FAIR Health, Inc. and/or Data iSight to determine Usual and Customary Charges. No payment will be made under the Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

When the Policy includes Preferred Provider benefits, the Usual and Customary Charges for Out-of-Network Emergency Services will be determined based on the lesser of a negotiated rate between the provider and Company that is accepted by the provider or the actual billed charge.

Section 9: 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. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
3. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Learning disabilities. Milieu therapy. Parent-child problems.
   This exclusion does not apply to benefits specifically provided in the Policy or to any screening or assessment specifically provided under the Preventive Care Services benefit.
4. Circumcision, except as specifically provided for a Newborn Infant during an Inpatient maternity Hospital stay provided under the Benefits for Maternity Expenses.
5. Cosmetic procedures, except:
   - To treat or correct Congenital Conditions of a Newborn Infant and Adopted or Foster Child.
   - Reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
6. 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.
7. Dental treatment, except:
   - For accidental Injury to Natural Teeth.

   This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit or benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Elective abortion.
10. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
11. Foot care that is palliative or cosmetic in nature,
    - Supportive devices for the foot, except for foot orthotics custom molded to the Insured.
    - Routine foot care for hygiene and preventive maintenance of feet including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

    This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
12. Health spa or similar facilities. Strengthening programs.
13. Hearing examinations, except as specifically provided in the Benefits for Newborn Hearing Screening. Hearing aids, except as specifically provided in the Benefits for 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.
    - Any screening or assessment specifically provided under the Preventive Care Services benefit.
14. Hypnosis, except when used for control of acute or chronic pain.
15. 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. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit.
16. 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.
17. Investigational services, except as specifically provided in the Benefits for Covered Clinical Trials.
18. Lipectomy.
19. Voluntary participation in a riot or civil disorder. Commission of or attempt to commit a felony.

20. 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 for Medical Supplies or as specifically provided in Benefits for Diabetes.
    - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs. This exclusion does not apply to Prescription Drugs used in covered phases I, II, III and IV clinical trials or for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The National Comprehensive Cancer Network Drugs and Biologics Compendium; (2) The Thomson Micromedex DrugDex; (3) The Elsevier Gold Standard's Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.
    - 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.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
21. Reproductive services including but not limited to the following, except as specifically provided in the Policy for Infertility Services:
    - Procreative counseling.
    - Genetic counseling and genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Premarital examinations.
    - Reversal of sterilization procedures.
22. 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 Benefits for Covered Clinical Trials.
23. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To therapeutic contact lenses when used as a corneal bandage.
    - To one pair of eyeglasses or contact lenses due to a prescription change following cataract surgery.
    - To any screening or assessment specifically provided under the Preventive Care Services benefit.
24. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
25. Preventive care services which are not 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.

    This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit or any North Carolina mandated benefit included under the Policy.
26. Services provided normally without charge by the Health Service of the Policyholder.
27. Services or supplies for the treatment of an occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
28. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
29. Speech therapy for stammering or stuttering. Holistic medicine services performed by any Physician or provider.
30. Supplies, except as specifically provided in the Policy.
31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
33. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

34. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Care Services benefit.

Section 10: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the college or university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 180 days after the date of service or as soon as reasonably possible to be considered for payment. If the Insured doesn't provide this information within one year and 180 days from 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:

FirstStudent
P.O. Box 809025
Dallas, TX 75380-9025

Section 11: General Provisions

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Insured has given the Company written notice of discontinuance.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025, or to any authorized agent of the Company with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 180 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid within 30 calendar days upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than 30 days of receipt of the claim, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Within 30 days of receipt of the claim, the Company may request additional information in order to process all or part of the claim. If the requested additional information is not received within 90 days after the request is made, the Company shall deny the claim and send notice of the denial. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid. Payment of claims not made in accordance with these provisions shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid.

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

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

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made. This provision does not apply to recovery of third party liability settlements.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

CERTIFICATE OF CREDITABLE COVERAGE: A certificate of creditable coverage will be provided to the Insured at the time coverage ceases under the Policy and upon request on behalf of the Insured made no later than 24 months after the date coverage ended. The certification will be a written certification of the period of creditable coverage of the Insured under the Policy and any waiting period and affiliation period, if applicable, imposed with respect to the Insured for any coverage under the Policy.

Section 12: Rebates / Inducements

From time to time the Company may offer or provide certain persons who become Insureds with the Company with discounts for goods or services. In addition, the Company may arrange for third party service providers such as pharmacies, optometrists, and dentists to provide discounted goods and services to those persons who become Insureds of the Company. While the Company has arranged these goods, services and/or third party provider discounts, the third party service providers are liable to the Insureds for the provision of such goods and/or services. The Company is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Company is not liable to the Insured for the negligent provision of such goods and/or services by the third party service providers.

Section 13: Grievance Procedures

An Insured Person may voluntarily request a review of any decision, policy, or action made by the Company that affects the Insured through the Grievance Review Process. An Insured Person may not submit a Grievance for a decision rendered by the Company solely on the basis that the policy does not provide benefits for the health service in question.

The Insured may contact the North Carolina Department of Insurance for assistance with Grievance Procedures at:

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free Telephone: (855) 408-1212

In Person:
For the physical address for Health Insurance Smart NC, please visit the webpage:
http://www.ncdoi.com/Smart/Smart_Contacts.aspx
Toll Free Telephone: (855) 408-1212
www.ncdoi.com/Smart for External Review and Request Form

Grievance Review Procedures

First-Level Grievance Review

The Insured Person or their Authorized Representative has the right to submit all Grievances to the Company for review.

The written Grievance review request should include:

1. A statement specifically requesting to submit a Grievance;
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 for the submission of the Grievance; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 1-800-505-4160 with any questions regarding the internal Grievance review process. The written request for an internal Grievance review should be sent to: Claims Appeals, FirstStudent, PO Box 809025, Dallas, TX 75380-9025.

An Insured or an Insured's Authorized Representative may submit all Grievances to the Company for review. Within 3 business days after receiving a Grievance, other than a Grievance concerning the quality of clinical care received by the Insured, the Company shall provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material.

For a Grievance concerning the quality of clinical care delivered by the Insured's provider, the Company shall provide acknowledgement of the Grievance to the Insured within 10 business days advising the Insured Person of the following:

1. The Company will refer the Grievance to its quality assurance committee for review and consideration or any appropriate action against the provider; and
2. North Carolina state law does not allow for a second-level Grievance review for a Grievance concerning quality of care.

The Grievance will not be reviewed by the same person or persons who initially handled the matter that is the subject of the Grievance. If the Grievance is of a clinical issue, at least one of the person or persons reviewing the Grievance shall be a medical doctor with appropriate expertise to evaluate the matter.

The Company shall issue a written decision to the Insured or the Insured's Authorized Representative within 30 days after receiving a Grievance. The written decision issued in a first-level Grievance review shall contain:

1. The professional qualifications and licensure of the person or persons reviewing the Grievance;
2. A statement of the reviewer's understanding of the Grievance;
3. The reviewer's decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Company's position;
4. A reference to the evidence or documentation used as the basis for the decision;
5. A statement advising the Insured Person of the their right to request a second level Grievance review and a description of the procedure for submitting a second level Grievance; and
6. Notice that the Health Insurance Smart NC is available for assistance through the North Carolina Department of Insurance at:

   By Mail:
   North Carolina Department of Insurance
   Health Insurance Smart NC
   1201 Mail Service Center
   Raleigh, NC 27699-1201
   Toll free telephone: (855) 408-1212

   In Person:
   For the physical address for Health Insurance Smart NC, please visit the webpage:
   http://www.ncdoi.com/Smart/Smart_Contacts.aspx
   Toll Free Telephone: (855) 408-1212
   www.ncdoi.com/Smart for External Review and Request Form

Second-Level Grievance Review

An Insured or an Insured's Authorized Representative may submit a request for a second-level Grievance review when not satisfied with the first-level Grievance review decision. This second-level review is not available for Grievances concerning quality of care.

The Company shall, within 10 business days after receiving a request for a second-level Grievance review, provide notice of the following information:

1. The name, address, and telephone number of the designated person coordinating the Grievance review for the Company;
2. A statement of the Insured Person's rights, including:
   a. the right to request and receive from the Company all information relevant to the case;
   b. the right to attend the second-level Grievance review;
   c. present his or her case to the review panel;
   d. submit supporting materials before and at the review meeting,
   e. ask questions of any member of the review panel; and
   f. be assisted or represented by a person of his or her choice, which may be without limitation to a provider, family member, employer representative, or an attorney. If the Insured Person chooses to be represented by an attorney, the Company may also be represented by an attorney.
3. Notice that the Health Insurance Smart NC is available for assistance through the North Carolina Department of Insurance at:

   By Mail:
   Health Insurance Smart NC
   North Carolina Department of Insurance
   1201 Mail Service Center
   Raleigh, NC 27699-1201
   Toll free telephone: (855) 408-1212

   In Person:
   For the physical address for Health Insurance Smart NC, please visit the webpage:
   http://www.ncdoi.com/Smart/Smart_Contacts.aspx
   Toll Free Telephone: (855) 408-1212
   www.ncdoi.com/Smart for External Review and Request Form

The Company shall convene a second-level Grievance review panel for each request. The panel shall be comprised of persons who were not previously involved in any matter giving rise to the second-level Grievance review, are not employees of the Company, and do not have a financial interest in the outcome of the review. All persons reviewing a second-level Grievance involving clinical issue must be providers who have appropriate expertise, including at least one clinical peer. When the second-level review panel is comprised of three persons or more and a clinical peer was used on the first-level Grievance review panel, the Company may use one of the Company's employees on the second-level Grievance review panel in place of a clinical peer.

The second-level review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review. The Insured Person shall be notified in writing within at least 15 days before the review meeting date. The Insured Person's right to a full review will not be conditioned on the Insured's appearance at the review meeting.

The Company shall issue a written decision to the Insured or an Insured's Authorized Representative within 7 business days after completing the review meeting. The decision shall include:

1. The professional qualifications and licensure of the members of the review panel;
2. A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
3. The review panel's recommendation to the Company and the rationale behind the recommendation;
4. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation;
5. The rationale for the Company's decision if the decision differs from the review panel's recommendation.
6. A statement that the decision is the Company's final determination in the matter;
7. Notice of the availability of the Commissioner's office for assistance; including the telephone number and address of the Commissioner's office; and

8. Notice that the Health Insurance Smart NC is available for assistance through the North Carolina Department of Insurance at:

By Mail:
Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free Telephone: (855) 408-1212

In Person:
For the physical address for Health Insurance Smart NC, please visit the webpage:
http://www.ncdoi.com/Smart/Smart_Contacts.aspx
Toll Free Telephone: (855) 408-1212
www.ncdoi.com/Smart for External Review and Request Form

Grievance Procedures Definitions

For the purpose of this Grievance Procedure provision, the following terms are defined as shown below:

Authorized Representative means:
1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

Grievance means a written complaint submitted by or on behalf of an Insured Person regarding:
1. The Company's decisions, policies, or actions related to availability, delivery or quality of health care services;
2. Claims payment, handling or reimbursement for health care services; or
3. The contractual relationship between an Insured Person and the Company.

Grievance" does not mean a decision rendered solely on the basis the policy does not provide benefits for the health care services in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

Section 14: Notice of Utilization Reviews and Internal Appeal and External Independent Review Procedures for NonCertifications and Adverse Determinations

Utilization Review

Prospective and Concurrent Utilization Review determinations shall be communicated to the Insured Person's provider within 3 business days after the Company obtains the necessary information about the admission, procedure, or health care service. Necessary information includes the results of any patient examination, clinical evaluation, or second opinion that may be required.

1. If the Company certifies the health care service, the Company will notify the Insured Person's treating provider.
2. For a Noncertification, the Company will notify the Insured Person's treating provider and send written or electronic confirmation of the Noncertification to the Insured Person. For Concurrent reviews, until the Insured Person receives notification of the Noncertification, the Company will remain liable for the health care services.

For Retrospective Reviews, the Company will make the determination within 30 days after receiving all necessary information.

1. When the heath care service is certified, the Company will provider written notice to the Insured Person's treating provider.
2. Within 5 business days of making the determination of Noncertification, the Company will provide written notice to the Insured Person and the Insured's provider.

A written notification of a Noncertification shall include all reasons for the Noncertification, including the clinical rationale and instructions on how to initiate a voluntary internal appeal for the Noncertification. The notification shall include information on the availability of assistance from the Health Insurance Smart NC, including the telephone number and address of the Program and include a notice of the Insured Person's right to file an external review with the Commissioner of the North Carolina Department of Insurance. The notice shall also include a statement explaining that if the Insured Person has a medical condition where the time frame for completion of an expedited internal review would reasonably be expected to seriously jeopardize the life or health of the Insured Person, the Insured Person may file a request for an expedited external review at the same time the Insured Person files for an expedited internal review. The notice shall also explain that the Commissioner will determine whether the covered person shall be required to complete the internal expedited review before conducting the expedited external review.

The Company shall provide the clinical review criteria used to make the Noncertification to any person who received the notification of the Noncertification and who follows the procedures for a request.

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

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

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at 1-800-505-4160 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: FirstStudent, PO Box 809025, Dallas, TX 75380-9025.

Internal Appeal Process
Within 180 days after receipt of a notice of a Noncertification or Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of a Noncertification or Adverse Determination. The Insured Person or an Authorized Representative is allowed to review the Insured Person's file, present evidence and testimony as part of the internal appeal process. The Insured Person will receive continued coverage in relation to the Noncertification or Adverse Determination pending the outcome of the internal appeal. This internal appeal process is free of charge to the Insured Person.

Within 3 calendar days after receiving a request for a standard, nonexpedited internal appeal, the Company shall provide the Insured Person with the name, address and telephone number of the coordinator and information on how to submit written material.

An expedited internal appeal of a Noncertification or Adverse Determination may be requested by an Insured Person or the Insured's provider only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of an Insured Person or jeopardize the Insured's ability to regain maximum function.

In consultation with a medical doctor licensed to practice medicine in the state of North Carolina, the Company shall provide written notification of the decision to the Insured Person and the Insured's provider:

1. Within 30 days after the request for a nonexpedited appeal; or
2. As soon as reasonably possible, but not later than 3 calendar days after receipt of information justifying the expedited review.

If the decision is not in favor of the Insured Person, the final written appeal decision shall contain the following information:

1. Information identifying the claim, including the following:
   a. The date of service;
   b. The health care provider; and
   c. The claim amount;
2. A statement describing the availability of the diagnosis code and treatment code and their corresponding meaning, upon request;
3. The professional qualifications and licensure of the person(s) reviewing the appeal;
4. A statement of the reviewer's understanding of the reason for the Insured's appeal;
5. The reviewer's decision in clear terms and the medical rationale in sufficient detail for the Insured to respond further to the Company's decision;
6. A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria;
7. The following statement disclosing the availability and contact information for Health Insurance Smart NC:

   Services provided by the Health Insurance Smart NC are available through the North Carolina Department of Insurance. To reach this Program, contact:

   By Mail:
   Health Insurance Smart NC
   North Carolina Department of Insurance
   1201 Mail Service Center
   Raleigh, NC 27699-1201
   Toll free Telephone: (855) 408-1212

   In Person:
   For the physical address for Health Insurance Smart NC, please visit the webpage:
   http://www.ncdoi.com/Smart/Smart_Contacts.aspx
   Toll Free Telephone: (855) 408-1212
   www.ncdoi.com/Smart for External Review and Request Form

8. The Insured Person's right to file an external review with the Commissioner of the North Carolina Department of Insurance, including the telephone number and address of the Commissioner.
9. A statement explaining that if the Insured Person has a medical condition where the time frame for completion of an expedited internal review would reasonably be expected to seriously jeopardize the life or health of the Insured Person, the Insured Person may file a request for an expedited external review at the same time the Insured Person files for an expedited internal review. And the Commissioner will determine whether the covered person shall be required to complete the internal expedited review before conducting the expedited external review.

Expedited Internal Review

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

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

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

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

Expedited Internal Review Process
The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:

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

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

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

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

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

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

External Independent Review

North Carolina law provides for review of Noncertification or Adverse Determination decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to the Insured, arranging for an IRO to review the Insured's case once the NCDOI establishes that the request is complete and eligible for review. The Company will notify the Insured in writing of their right to request an external review each time a Noncertification decision or an appeal decision upholding a Noncertification decision. Within 120 days after the date of receipt of the above notifications, the Insured Person may file a request with the Commissioner of the NCDOI for an external review.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. Rescissions of coverage are not eligible for External Review in the state of North Carolina but will be reviewed at the Internal Appeals level.

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

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free telephone: (855) 408-1212

In Person:
For the physical address for Health Insurance Smart NC, please visit the webpage:
http://www.ncdoi.com/Smart/Smart_Contacts.aspx
Toll Free Telephone: (855) 408-1212
www.ncdoi.com/Smart for External Review and Request Form

Standard External Review (SER) Process

In order for the request to be eligible for external review, the NCDOI must conduct a preliminary review to determine the following:

1. The Insured has provided all information and forms required by the Commissioner necessary to process an external review;
2. The Insured had coverage with the Company in effect when the Noncertification or Grievance decision was issued;
3. The service for which the Noncertification was issued appears to be a covered service under the policy; and
4. The Insured has exhausted the Company's internal review processes as described above.

The Insured will be considered to have exhausted the internal review process if the Insured has:

1. completed the Company's internal appeal of Noncertification process and received a written determination from the Company; or
2. filed an Internal appeal and except to the extent that the Insured has requested or agreed to a delay; has not received the Company's written decision within 60 days of the date the request was submitted or has received notification from the Company agreeing to waive the requirement to exhaust the internal appeal of Noncertification.

Upon receipt of a request for a SER, the Commissioner, within 10 business days:

1. Notify and send a copy of the request to the Company and require the Company to provide, within 3 business days or receipt of notice, any information the Commissioner requires to conduct the preliminary review;
2. Conduct a preliminary review;
3. Notify the Insured Person and the Insured Person's provider who performed or requested the service whether the request is complete and has been accepted for SER;
    a. If the preliminary review finds that the request for SER is not complete, the Commissioner will request the Insured to furnish, within 150 days after the date of the Company's decision for which the SER was requested, the information or materials needed to make the request complete; or
    b. If the preliminary review finds that the request for SER is not accepted for external review, the Commissioner will notify in writing the Insured Person, the Insured Person's provider who performed or requested the service, and the Company of the reasons for its nonacceptance.
4. Assign the review to an IRO;
5. Forward to the assigned IRO any documents that were received relating to the request for a SER;
6. Notify the Company in writing whether the request for SER has been accepted. If the request has been accepted, the notice shall direct the Company to provide the IRO and the Insured or the Insured's Authorized Representative, within 7 business days, with the documents and any information considered in making the Noncertification appeal decision;
7. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Noncertification appeal decision. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
8. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
9. If the Commissioner receives any additional information from the Insured Person or the Authorized Representative, the Commissioner will forward the information to the IRO within 2 business day or receiving it and shall forward a copy of the information to the Company.
    a. The Company may then reconsider its Noncertification appeal decision subject to the SER. Reconsideration by the Company shall not delay or terminate the SER.
    b. The SER may only be terminated if the Company decides to reverse its Noncertification appeal decision and provide coverage for the service that is the subject of the SER.
    c. If the Company reverses it decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
10. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Noncertification appeal decision. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative.

Upon receipt of a notice of decision reversing the Noncertification appeal decision, the Company shall, within 3 business days, provide coverage or payment for the requested health care service or supply that was the subject of the Noncertification appeal decision.

If the Insured Person is no longer covered by the Company at the time the Company receives notice of the IRO's decision to reverse the Noncertification, the Company will only provide coverage for those services or supplies the Insured actually received or would have received prior to disenrollment if the service had not been Noncertified when first requested.

Expedited External Review (EER) Process

The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the NCDOI at the time the Insured Person receives:

1. A Noncertification decision if:
   a. the Insured Person or the Authorized Representative has filed a request for an expedited appeal of Noncertification; and
   b. the Noncertification involves a medical condition for which the timeframe for completing an expedited appeal of Noncertification would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. An appeal decision upholding a Noncertification, if:
   a. the Noncertification involves a medical condition for which the timeframe for completing an expedited Internal review of a Noncertification would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; and
   b. the Insured Person or Authorized Representative has filed a request for an expedited internal review of a Noncertification.

An EER may not be provided for Retrospective Noncertifications.

Upon receipt of a request for an EER, the Commissioner, within three (3) calendar days shall:

1. Notify and send a copy of the request to the Company and require the Company to provide, within one day after receiving the notice any information the Commissioner requires to conduct the preliminary review;
2. Conduct a preliminary review;
3. Notify the Insured Person and the Insured Person's provider who performed or requested the service whether the request is complete and has been accepted for SER;
4. For an EER made involving an Insured with a medical condition for which the timeframe for completing a review other than an EER could seriously jeopardize the life or health of the Insured or jeopardize the Insured's ability to regain maximum function; determine, based on medical advice from a medical professional not affiliated with the IRO that will be assigned to conduct the EER, whether the request should be reviewed on an expedited basis.
5. Notify the Insured Person and the Insured Person's provider who performed or requested the service whether the request is complete and has been accepted for an EER.
6. Assign the EER to an IRO, if the request is determined to be accepted for an EER;
7. If the request is determined to not be accepted for an EER, notify the Insured or the Insured's Authorized Representative and the Insured's provider whether the review will be conducted using an expedited or standard time frame or if the Insured must exhaust the Company's internal appeal process before making another request for an external review with the Commissioner.
8. If the request is determined accepted for an EER, forward to the assigned IRO any documents that were received relating to the request for a EER;
9. Notify the Company in writing whether the request for SER has been accepted. If the request has been accepted, the notice shall direct the Company to provide the IRO and the Insured or the Insured's Authorized Representative, within the same day as receiving notification of acceptance of the request for EER, with the documents and any information considered in making the Noncertification or Adverse Determination appeal decision;
10. In no more than 3 days after receipt of the qualifying EER request, the IRO shall:
    a. Make a decision to uphold or reverse the Noncertification, Noncertification appeal decision; or Adverse Determination and
    b. Notify the Insured Person or the Authorized Representative; the Insured's provider, the Commissioner, and the Company.
11. If the notice of decision was not provided in writing, within 2 days after the date of providing the notice, the IRO shall provide written confirmation of the decision to the Insured Person or Authorized Representative, the Insured's provider, the Commissioner, and the Company

Upon receipt of a notice of decision reversing the Noncertification, Noncertification appeal decision, or Adverse Determination, the Company shall immediately, within 1 business day, approve the coverage that was the subject of the Noncertification, Noncertification appeal decision, or Adverse Determination.

BINDING EXTERNAL REVIEW

An External Review decision is binding on the Company except to the extent the Company has other remedies available under state law. An External Review decision is binding on the Insured Person to the extent the Insured Person has other remedies available under applicable federal or state law. An Insured Person or an Authorized Representative may not file a subsequent request for External Review involving the same Noncertification appeal decision or Adverse Determination for which the Insured Person has already received an External Review decision.

APPEAL RIGHTS DEFINITIONS

For the purpose of this Notice of Appeal Rights, the following terms are defined as shown below:

Adverse Determination means:

1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy as an Insured Person;
3. Any prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy; or
4. A rescission of coverage.

Ambulatory Review means Utilization Review of services performed or provided in an outpatient setting.

Authorized Representative means:

1. A person to whom an Insured Person has given express written consent to represent the Insured Person.
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

Case Management means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

Certification means a determination by the Company or its designated Utilization Review Organization that an admission, availability of care, continued stay, or other service has been reviewed an, based on the information provided, satisfies the Company's requirements for Medically Necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.

Concurrent Review means Utilization Review conducted during an Insured's hospital stay or course of treatment.

Discharge Planning means the formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.

Evidenced–based Standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

Noncertification means a determination by the Company or its designated Utilization Review Organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage under the Benefits for Emergency Services, and the requested service is therefore denied, reduced, or terminated. A "Noncertification" includes any situation in which the Company or its designated Utilization Review Organization makes a decision about an Insured Person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the policy is affected by that decision. "Noncertification" does not mean a decision rendered solely on the basis the policy does not provide benefits for the health care services in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

Prospective Review means Utilization Review conducted before an admission or a course of treatment including any required preauthorization or precertification.

Retrospective Review means Utilization Review of Medically Necessary services and supplies that are conducted after services have been provided to a patient not the review of a claim that is limited to the veracity of documentation, accuracy of coding or adjudication for payment.. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard under the Benefits for Emergency Services has been met.

Second Opinion means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

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

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include Ambulatory Review, Prospective Review, Second Opinion, Certification, Concurrent Review, Case Management, Discharge Planning, or Retrospective Review.

Questions Regarding Appeal Rights
Contact Customer Service at 1-800-505-4160 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free telephone: (855) 408-1212

In Person:
For the physical address for Health Insurance Smart NC, please visit the webpage:
http://www.ncdoi.com/Smart/Smart_Contacts.aspx
Toll Free Telephone: (855) 408-1212
www.ncdoi.com/Smart for External Review and Request Form

Section 15: Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID cards, network providers, correspondence, and coverage information by logging in to ***My Account*** at www.firststudent.com. 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 the Insured's 7-digit Insurance ID number or the email address on file.

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

My Account now includes Message Center - a self-service tool that provides a quick and easy way to view any email notifications the Company 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.

Section 16: ID Cards

Digital ID cards will be made available to each Insured Person. The Company will send an email notification when the digital ID card is available to be downloaded from ***My Account***. An Insured Person may also use ***My Account*** to request delivery of a permanent ID card through the mail.

Section 17: UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating healthcare or Mental Health providers, find contact information for the provider's office or facility, and locate the provider's office or facility on a map.
- Find My Claims – view claims received within the past 120 days for both the primary Insured and covered Dependents; includes provider, date of service, status, claim amount and amount paid.

Section 18: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
FirstStudent
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-505-4160
Web site: www.firststudent.com

Schedule of Benefits

Pfeiffer University
2017-939-61
METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 82.570%
Injury and Sickness Benefits

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

Deductible Preferred Provider	**$250 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network	**$500 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Provider	**80%**
Coinsurance Out-of-Network	**60%**
Out-of-Pocket Maximum Preferred Provider	**$6,000 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Provider	**$12,000 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$15,000 (Per Insured Person, Per Policy Year)**

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

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

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 Coinsurance, Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays.

Student Health Center: The Deductible and Copays will be waived and benefits will be paid at 100% of billed charges when treatment is rendered at the Student Health Center. Policy Exclusions and Limitations do not apply.

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 of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available.

Covered Medical Expenses include:

NOTICE: The Insured's actual costs for Covered Medical Expenses may exceed the stated Coinsurance or Copayment amount because actual provider charges may not be used to determine Policy and Insured payment obligations.

Inpatient	Preferred Provider	Out-of-Network Provider
Room and Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing Payable within 7 working days prior to admission.	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital. See Out-of-Network Medical Emergency Services, page 3.	Preferred Allowance $150 Copay per visit	80% of Usual and Customary Charges $150 Copay per visit
Diagnostic X-ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	*UnitedHealthcare Pharmacy (UHCP) $15 Copay per prescription Tier 1 $35 Copay per prescription Tier 2 $60 Copay per prescription Tier 3 up to a 31 day supply per prescription When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times 31 day supply retail Copay (up to 50% of the Prescription Drug Charge). Mail order Prescription Drugs through UHCP at 2.5 times the 31 day supply retail Copay for up to a 90-day supply. If a retail UnitedHealthcare Network Pharmacy agrees to the same rates, terms and requirements associated with dispensing a 90 day supply, then up to a consecutive 90 day supply of a Prescription Drug at 2.5 times the Copay that applies to a 31 day supply per prescription.	$15 Copay per prescription generic drug $35 Copay per prescription brand-name drug up to a 31-day supply per prescription

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	Preferred Allowance	80% of Usual and Customary Charges
Durable Medical Equipment	Preferred Allowance	80% of Usual and Customary Charges
Consultant Physician Fees	Preferred Allowance	Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Natural Teeth only.	Preferred Allowance	80% of Usual and Customary Charges
Mental Illness Treatment	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment See Benefits for Treatment for Chemical Dependency	Paid as any other Sickness	Paid as any other Sickness
Maternity See Benefits for Maternity Expenses	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	No Benefits	No Benefits
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider	Out-of-Network Provider
Diabetes Services See Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness
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 $50 Copay per visit	Usual and Customary Charges $50 Copay per visit
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials See Benefits for Covered Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Infertility Services	Paid as any other Sickness	Paid as any other Sickness
Medical Supplies Benefits are limited to a 31-day supply per purchase	Preferred Allowance	Usual and Customary Charges
Ostomy Supplies Benefits are limited to a 31-day supply per purchase	Preferred Allowance	Usual and Customary Charges
Sexual Dysfunction	Paid as any other Sickness	Paid as any other Sickness
Sterilization	Paid as any other Sickness	Paid as any other Sickness
Nutritional Counseling	Paid as any other Sickness	Paid as any other Sickness
Titers Coverage only includes titers related to immunizations for the following: Polio Virus Immune status, Varicella-Zoster AB, IgG, Hepatitis B surf AB, MMR, Hep B, Hep A, Tdap, and Rubella.	Preferred Allowance	Usual and Customary Charges
Tuberculosis Screening and Testing Coverage includes TB Screening and Testing not covered under the Preventive Care Services benefit	Preferred Allowance	Usual and Customary Charges

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all of the terms and conditions of the Policy not inconsistent therewith.

President

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

Pediatric Dental Services Benefits

Benefits are provided under this endorsement for Covered Dental Services, as described below, for Insured Persons under the age of 19. Benefits under this endorsement 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 - these 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 Person 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. The Insured Person can verify the participation status by calling the Company and/or the provider. If necessary, the Company can provide assistance in referring the Insured Person to Network Dental Provider.

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

Non-Network Benefits - these 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, Insured Persons 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 Person must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

The Insured Person is eligible for benefits for Covered Dental Services listed in this endorsement 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 under this endorsement.

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 notify the Company of such treatment before treatment begins and 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. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

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 Exclusions* of this endorsement.

Benefits for Covered Dental Services are subject to satisfaction of the Dental Services Deductible.

Network Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge the Insured Person or the Company for any service or supply that is not Necessary as determined by the Company. If the Insured Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Insured Person. However, these charges will not be considered Covered Dental Services and benefits will not be payable.

Non-Network Benefits:

Benefits for Eligible Dental Expenses from non-Network providers are determined as a percentage of the Usual and Customary Fees. The Insured Person must pay the amount by which the non-Network provider's billed charge exceeds the Eligible Dental Expense.

Dental Services Deductible
Benefits for pediatric Dental Services provided under this endorsement 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 endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*. Any amount the Insured Person pays in Copayments for pediatric Dental Services under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*.

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

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

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 - (Subject to payment of the Dental Services Deductible.)		
Evaluations (Checkup Exams) *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. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D0150 - Comprehensive oral evaluation D0180 - Comprehensive periodontal evaluation *The following service is not*	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.
subject to a frequency limit. D0160 - Detailed and extensive oral evaluation - problem focused		
Intraoral Radiographs (X-ray) *Limited to 2 series of films per 12 months.* D0210 - Complete series (including bitewings)	50%	50%
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first film D0230 - Intraoral - periapical - each additional film D0240 - Intraoral - occlusal film	50%	50%
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films D0277 - Vertical bitewings	50%	50%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image	50%	50%
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray D0350 - Oral/Facial photographic images D0391 - Interpretation of diagnostic images D0470 - Diagnostic casts	50%	50%
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) *The following services are limited to 2 times every 12 months.* D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	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.
Fluoride Treatments *The following services are limited to 2 times every 12 months.* D1206 and D1208 - Fluoride	50%	50%
Sealants (Protective Coating) *The following services are limited to once per first or second permanent molar every 36 months.* D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	50%	50%
Space Maintainers (Spacers) *The following services are not subject to a frequency limit.* D1510 - Space maintainer - fixed - unilateral D1515 - Space maintainer - fixed - bilateral D1520 - Space maintainer - removable - unilateral D1525 Space maintainer - removable bilateral D1550 - Re-cementation of space maintainer	50%	50%
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings) *The following services are not subject to a frequency limit.* D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	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.
Composite Resin Restorations (Tooth Colored Fillings) *The following services are not subject to a frequency limit.* D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
The following services are subject to a limit of 1 time every 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four surfaces D2740 - Crown - porcelain/ceramic substrate D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2780 - Crown - 3/4 case high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal	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.
D2794 Crown – titanium D2929 – Prefabricated porcelain crown - primary D2930 Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth *The following services are not subject to a frequency limit.* D2510 Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement inlay D2920 - Re-cement crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following service is limited to 1 time per tooth every 60 months. D2950 - Core buildup, including any pins	50%	50%
The following service is limited to 1 time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to Crown	50%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 – Inlay repair D2982 – Onlay repair	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.
D2983 – Veneer repair D2990 – Resin infiltration/smooth surface		
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration)	50%	50%
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for Apexogenesis - Permanent tooth with incomplete root development	50%	50%
The following services are not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior. primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit. D3310 - Anterior root canal (excluding final restoration) D3320 - Bicuspid root canal (excluding final restoration) D3330 - Molar root canal (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar	50%	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification -	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.
interim medication replacement D3353 - Apexification/recalcification - final visit		
The following service is not subject to a frequency limit. D3354 - Pulpal Regeneration	50%	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root	50%	50%
The following service is not subject to a frequency limit. D3450 - Root amputation - per root	50%	50%
The following service is not subject to a frequency limit. D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more teeth D4211 - Gingivectomy or gingivoplasty - one to three teeth D4212 - Gingivectomy or gingivoplasty – with restorative procedures – per tooth	50%	50%
The following services are limited to 1 every 36 months. D4240 - Gingival flap procedure,	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.
four or more teeth D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant		
The following service is not subject to a frequency limit. D4249 - Clinical crown lengthening - hard tissue	50%	50%
The following services are limited to 1 every 36 months. D4260 - Osseous surgery D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant D4263 - Bone replacement graft – first site in quadrant	50%	50%
The following services are not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure D4271 - Free soft tissue graft procedure	50%	50%
The following services are not subject to a frequency limit. D4273 - Subepithelial connective tissue graft procedures, per tooth D4275 - Soft tissue allograft D4277 - Free soft tissue graft - first tooth D4278 - Free soft tissue graft - additional teeth	50%	50%
The following services are limited to 1 time per quadrant every 24 months. D4341 - Periodontal scaling and root planning - four or more teeth per quadrant D4342 - Periodontal scaling and root planning - one to three teeth per quadrant	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.
The following service is limited to a frequency to 1 per lifetime. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis	50%	50%
The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Mandibular partial denture - resin base D5212 - Maxillary partial denture - resin base D5213 - Maxillary partial denture - cast metal framework with resin denture base D5214 - Mandibular partial denture - cast metal framework with resin denture base D5281 - Removable unilateral partial denture - one piece cast metal	50%	50%
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture -	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.
mandibular D5510 - Repair broken complete denture base D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5620 - Repair cast framework D5630 - Repair or replace broken clasp D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture		
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5730 - Reline complete maxillary denture D5731 - Reline complete mandibular denture D5740 - Reline maxillary partial denture D5741 - Reline mandibular partial denture D5750 - Reline complete maxillary denture (laboratory) D5751 - Reline complete mandibular denture (laboratory) D5752 - Reline complete mandibular denture (laboratory) D5760 - Reline maxillary partial denture (laboratory)	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.
D5761 - Reline mandibular partial denture (laboratory) - rebase/reline D5762 - Reline mandibular partial denture (laboratory)		
The following services are not subject to a frequency limit. D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - case high noble metal D6211 - Pontic - case predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6245 - Pontic - porcelain/ceramic	50%	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are not subject to a frequency limit. D6519 - Inlay/onlay - porcelain/ceramic D6520 - Inlay - metallic - two surfaces D6530 - Inlay - metallic - three or	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.
more surfaces D6543 - Onlay - metallic - three surfaces D6544 - Onlay - metallic - four or more surfaces		
The following services are limited to 1 time every 60 months. D6740 - Crown - porcelain/ceramic D6750 - Crown - porcelain fused to high noble metal D6751 - Crown - porcelain fused to predominately base metal D6752 - Crown - porcelain fused to noble metal D6780 - Crown - 3/4 cast high noble metal D6781 - Crown - 3/4 cast predominately base metal D6782 - Crown - 3/4 cast noble metal D6783 - Crown - 3/4 porcelain/ceramic D6790 - Crown - full cast high noble metal D6791 - Crown - full cast predominately base metal D6792 - Crown - full cast noble metal	50%	50%
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond fixed partial denture	50%	50%
The following services are not subject to a frequency limit. D6973 - Core build up for retainer, including any pins D6980 - Fixed partial denture repair necessitated by restorative material failure	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following service is not	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.
subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root		
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring elevation of mucoperioteal flap and removal of bone and/or section of tooth D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - complete bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal	50%	50%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - per quadrant D7321 - Alveoloplasty not in	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.
conjunction with extractions - one to three teeth or tooth space - per quadrant		
The following service is not subject to a frequency limit. D7471 - removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess D7910 - Suture of recent small wounds up to 5 cm D7921 - Collect - apply autologous product D7953 - Bone replacement graft for ridge preservation - per site D7971 - Excision of pericoronal gingiva	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure	50%	50%
Covered only when clinically Necessary. D9220 - Deep sedation/general anesthesia first 30 minutes D9221 - Dental sedation/general anesthesia each additional 15 minutes D9241 - Intravenous conscious sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9610 - Therapeutic drug injection, by report	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.
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	50%	50%
The following is limited to 1 guard every 12 months. D9940 - Occlusal guard	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to 1 time every 60 months. D6010 - Endosteal implant D6012 - Surgical placement of interim implant body D6040 - Eposteal Implant D6050 - Transosteal implant, including hardware D6053 - Implant supported complete denture D6054 - Implant supported partial denture D6055 - Connecting bar implant or abutment supported D6056 - Prefabricated abutment D6057 - Custom abutment D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to high noble metal D6060 - Abutment supported porcelain fused to predominately base metal crown D6061 - Abutment supported porcelain fused to noble metal crown D6062 - Abutment supported cast high noble metal crown D6063 - Abutment supported case predominately base metal crown D6064 - Abutment supported	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.
porcelain/ceramic crown D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported porcelain fused to high metal crown D6067 - Implant supported metal crown D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture D6072 - Abutment supported retainer for cast high noble metal fixed partial denture D6073 - Abutment supported retainer for predominately base metal fixed partial denture D6074 - Abutment supported retainer for cast metal fixed partial denture D6075 - Implant supported retainer for ceramic fixed partial denture D6076 - Implant supported retainer for porcelain fused to high noble metal fixed partial denture D6077 - Implant supported retainer for cast metal fixed partial denture D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch D6079 - Implant/abutment supported fixed partial denture for		

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.
partially edentulous arch D6080 - Implant maintenance procedure D6090 - Repair implant prosthesis D6091 - Replacement of semi-precision or precision attachment D6095 - Repair implant abutment D6100 - Implant removal D6101 - Debridement periimplant defect D6102 - Debridement and osseous periimplant defect D6103 - Bone graft periimplant defect D6104 - Bone graft implant replacement D6190 - Implant index		
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
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. 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.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8050 - Interceptive orthodontic treatment of the primary dentition D8060 - Interceptive orthodontic treatment of the transitional	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.
dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention		

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this endorsement 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. Benefits may be Covered Medical Expenses available under the Policy. Refer to the Medical Expense Benefits section of the Certificate.
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 Service 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. Benefits may be Covered Medical Expenses available under the Policy. Refer to the Medical Expense Benefits section of the Certificate.
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 becoming enrolled for coverage provided through this endorsement to the Policy.
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 Dental 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

If the Insured Person would like to use a claim form, call Customer Service at 1-877-816-3596. This number is also listed on the Insured's Dental ID Card. If the Insured Person does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in the Definitions section of the Certificate of Coverage:

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Usual and Customary Fee - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.
Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.
Usual and Customary Fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all the terms and conditions of the Policy not inconsistent therewith.

President

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

Pediatric Vision Care Services Benefits

Benefits are provided under this endorsement for Vision Care Services, as described below, for Insured Persons under the age of 19. Benefits under this endorsement 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 in this endorsement under *Section 3: Claims for Vision Care Services*. Reimbursement will be limited to the amounts stated below.

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

Network Benefits:

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

Non-Network Benefits:

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

Out-of-Pocket Maximum - any amount the Insured Person pays in Coinsurance for Vision Care Services under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*. Any amount the Insured Person pays in Copayments for Vision Care Services under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*.

Policy Deductible

Benefits for pediatric Vision Care Services provided under this endorsement 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 under this endorsement does not apply to the Policy Deductible stated in the Policy *Schedule of Benefits*.

Benefit Description

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.

Frequency of Service Limits

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 Person sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

Eyeglass Lenses

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

The 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.

If the Insured Person purchases *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks Vision Care Provider, only one Copayment will apply to those *Eyeglass Lenses* and *Eyeglass Fra*mes together.

Eyeglass Frames

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

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

If the Insured Person purchases *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks Vision Care Provider, only one Copayment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

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

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	50% of the billed charge.
• Bifocal		100% after a Copayment of $40.	50% of the billed charge.
• Trifocal		100% after a Copayment of $40.	50% of the billed charge.
• Lenticular		100% after a Copayment of $40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - $160.		100% after a Copayment of $15.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - $200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - $250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.
Contact Lenses Fitting & Evaluation	Once per year.	100%	50% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Low Vision Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
• Low vision testing		100% of the billed charge.	75% of the billed charge.
• Low vision therapy		100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this endorsement under *Section 1: Benefits for Pediatric Vision Care Services*, benefits are not provided under this endorsement 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. Information about claim timelines and responsibilities in the General Provisions section in the Certificate of Coverage applies to Vision Care Services provided under this endorsement, except that when the Insured Person submits a Vision Services claim, the Insured Person must provide the Company with all of the information identified below.

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 from the ID card.
- 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

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in Definitions section of the Certificate of Coverage:

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 this endorsement in *Section 1: Benefits for Pediatric Vision Care Services.*

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all of the terms and conditions of the Policy not inconsistent therewith.

President

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products when dispensed at a UHCP Network Pharmacy as specified in the Policy Schedule of Benefits subject to all terms of the Policy and the provisions, definitions and exclusions specified in this endorsement.

Benefits for Prescription Drug Products are subject to supply limits and Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the Policy Schedule of Benefits for applicable supply limits and Copayments and/or Coinsurance requirements.

Benefit for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Medical Expense.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after ¾ of the original Prescription Drug Product has been used except under certain circumstances during a state of emergency or disaster.

The Insured must present their ID card to the Network Pharmacy when the prescription is filled. If the Insured does not present their ID card to the Network Pharmacy, they will need to pay for the Prescription Drug and then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting www.firststudent.com and logging in to their online account or by calling *Customer Service* at 1-855-828-7716.

Information on Network Pharmacies is available through the Internet at www.firststudent.com or by calling *Customer Service* at 1-855-828-7716.

When prescriptions are filled at pharmacies outside a Network Pharmacy, the Insured must pay for the Prescription Drugs out of pocket and submit the receipts for reimbursement as described in the How to File a Claim for Injury and Sickness Benefits section in the Certificate of Coverage.

Copayment and/or Coinsurance Amount

For Prescription Drug Products at a retail Network Pharmacy, Insured Persons are responsible for paying the lowest of:

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance; or
- The Prescription Drug Charge for that Prescription Drug Product.

The Insured Person is not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size. For a single Copayment and/or Coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.firststudent.com or by calling *Customer Service* at 1-855-828-7716.

Refill Synchronization

The Company has a procedure to align the refill dates of Prescription Drug Products so that drugs that are refilled at the same frequency may be refilled concurrently. The Insured Person may access information on these procedures through the Internet at www.firststudent.com or by calling *Customer Service* at 1-800-505-4160.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change, and therefore the Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

Designated Pharmacies

If the Insured requires certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Pharmacy, the Insured may opt-out of the Designated Pharmacy program through the Internet at www.firststudent.com or by calling *Customer Service* at 1-855-828-7716. If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, benefits will be provided under the Out-of-Network Prescription Drug benefit.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, benefits will be provided under the Out-of-Network Prescription Drug benefit or, for a Specialty Prescription Drug Product, if the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If the Insured requires Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Specialty Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and the Insured has informed the Company of their decision not to obtain their Specialty Prescription Drug Product from a Designated Pharmacy, and the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

The Company designates certain Network Pharmacies to be Preferred Specialty Network Pharmacies. The Company may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to the Insured unless required by law. The Insured may determine whether a Network Pharmacy is a Preferred Specialty Network Pharmacy through the Internet at www.firststudent.com or by calling *Customer Service* at 1-855-828-7716.

If the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

Please see the Definitions Section for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The following supply limits apply to Specialty Prescription Drug Products.

As written by the Physician, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Notification Requirements

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Insured's Physician, Insured's pharmacist or the Insured is required to notify the Company or the Company's designee. The reason for notifying the Company is to determine whether the Prescription Drug Product, in accordance with the Company's approved guidelines, is each of the following:

It meets the definition of a Covered Medical Expense.
It is not an Experimental or Investigational or Unproven Service.

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. There may be certain Prescription Drug Products that require the Insured to notify the Company directly rather than the Insured's Physician or pharmacist. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.firststudent.com or by calling *Customer Service* at 1-855-828-7716.

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured can ask the Company to consider reimbursement after the Insured receives the Prescription Drug Product. The Insured will be required to pay for the Prescription Drug Product at the pharmacy.

When the Insured submits a claim on this basis, the Insured may pay more because they did not notify the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any Deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Company reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Medical Expense or it is an Experimental or Investigational or Unproven Service.

Limitation on Selection of Pharmacies

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person's selection of Network Pharmacies may be limited. If this happens, the Company may require the Insured to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the designated single Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will select a single Network Pharmacy for the Insured.

Coverage Policies and Guidelines

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

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

The Company may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to the Insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. Please access www.firststudent.com through the Internet or call *Customer Service* 1-855-828-7716 for the most up-to-date tier status.

Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company does not pass these rebates on to the Insured Person, nor are they applied to the Insured's Deductible or taken into account in determining the Insured's Copayments and/or Coinsurance.

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Endorsement. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

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, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, 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:

- 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.
- 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.)
- 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:

- Phases 1, 2, 3 or 4 clinical trials for which benefits are specifically provided for in the Policy.
- 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.

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, medi-span or 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 the Company's 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 the Company's PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy means a specialty Network Pharmacy that the Company identifies as a non-preferred pharmacy within the network.

Preferred Specialty Network Pharmacy means a specialty Network Pharmacy that the Company identifies as a preferred pharmacy within the network.

Prescription Drug or Prescription Drug Product means a medication or product 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:

- Inhalers.
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Drug Charge 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 or products 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.firststudent.com or call *Customer Service* 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.

Prescription Order or Refill means the directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Preventive Care Medications means the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, or Deductible) as required by applicable law under any of the following:

- 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.
- 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 as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Insured may determine whether a drug is a Preventive Care Medication through the internet at www.firststudent.com or by calling *Customer Service* 1-855-828-7716.

Restricted Drug means those covered Prescription Drugs or devices for which reimbursement by the Company is conditioned on the prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

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.firststudent.com or call *Customer Service* 1-855-828-7716.

Therapeutically Equivalent means when Prescription Drugs Products have essentially the same efficacy and adverse effect profile.

Unproven Service(s) means services, including medications, that are determined not to be effective for the treatment of the medical condition and/or not to have a beneficial effect on the health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- 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.)
- Well-conducted cohort studies from more than one institution. (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.)

The Company has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Company issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

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, as it determines, 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.

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.

Additional Exclusions

In addition to the Exclusions and Limitations shown in the Certificate of Coverage, the following Exclusions apply:

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, except as specifically provided in the Benefits for Covered Clinical Trials.
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 the Company's 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 contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided in the Policy.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. 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 that was previously excluded under this provision.

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. 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 that was previously excluded under this provision.
11. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. 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 that was previously excluded under this provision.
12. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. 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 that was previously excluded under this provision.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Durable medical equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
15. Diagnostic kits and products.
16. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-800-505-4160.. The Company will notify the Insured Person of the Company's determination within 72 hours.

Urgent Requests

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

External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-800-505-4160.. The *Independent Review Organization (IRO)* will notify the Insured Person of the determination within 72 hours.

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-800-505-4160. 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.

NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意：**如果您說中文 (Chinese)**，**我們免費為您提供語言協助服務。請致電**：1-866-260-2723.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-260-2723.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-260-2723.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-866-260-2723.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-260-2723.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-260-2723.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-260-2723.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-260-2723.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-260-2723 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-260-2723 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-866-260-2723 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-260-2723

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-260-2723។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-260-2723 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.

POLICY NUMBER: 2017-939-61

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.

NOC 1 - 10/04/2017
Policy:
N/A

Certificate:

The following was removed from the front cover:
EXCESS INSURANCE – The Policy is not intended to be issued where other medical insurance exists. If other medical insurance does exist at the time of the claim then the amounts of benefit payable by such other medical insurance will become the Deductible amount of the Policy if such benefits exceed the Deductible amount shown in the Schedule of Benefits.

Line items added to SOB-
Titers :
Preferred Allowance/Usual and Customary Charges
Coverage only includes titers related to immunizations for the following: Polio Virus Immune status, Varicella-Zoster AB, IgG, Hepatitis B surf AB, MMR, Hep B, Hep A, Tdap, and Rubella.

Tuberculosis Screening and Testing:
Preferred Allowance/Usual and Customary Charges
Coverage includes TB Screening and Testing not covered under the Preventive Care Services benefit

Nutritional Counseling:
Paid as any other Sickness/Paid as any other Sickness

SOB-
From:
Infertility Services- Preferred Allowance/Usual and Customary Charges

To:
Infertility Services- Paid as any other sickness/Paid as any other sickness