Benefits Booklet

Saudi Arabian Cultural Mission
Student Health Plan

Plan Year:

July 1, 2020
to
June 30, 2021

TABLE OF CONTENTS

Eligibility and Termination Provisions	4
General Provisions	4
Definitions	8
Schedule of Benefits	16
Benefit Provisions	21
Exclusions and Limitations	31
Pre-Admission Notification	35
UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits	36
Claim Denials and Appeals	41

The Saudi Arabian Cultural Mission (Plan Sponsor) is pleased to provide you with this Benefits Booklet (Booklet), which describes the health Benefits available to you and your Dependents under the Saudi Arabian Cultural Mission Student Health Plan (Plan).

IMPORTANT
The healthcare service, supply or Pharmaceutical Product is only a Covered Medical Expense if it is Medically Necessary. (See definitions of Medically Necessary and Covered Medical Expense the Definitions.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, Substance Use Disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Medical Expense under the Plan.

IMPORTANT
Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This Booklet is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

United HealthCare Services, Inc. (the Claims Administrator or Administrator) is a private healthcare claims administrator. The Claims Administrator's goal is to give you the tools you need to make wise healthcare decisions. The Claims Administrator also helps Plan Sponsor to administer claims. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Saudi Arabian Cultural Mission is solely responsible for paying Benefits described in this Booklet.

Please read this SPD thoroughly to learn how the Plan works. If you have questions call the number on the back of your ID card.

How To Use This Booklet

- Read the entire Booklet, and share it with your covered Dependents. Then keep it in a safe place for future reference.
- Many of the sections of this Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your Booklet and any future amendments at uhcsr.com/SACM.
- Capitalized words in the Booklet have special meanings and are defined in the Definitions.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in the Definitions.
- If there is a conflict between this Booklet and any Benefit summaries (other than Summaries of Material Modifications) provided to you, this Booklet will control.

PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Any sponsored Saudi national enrolled in a scholarly program in the United States pursuant to a valid student visa issued by the United States and any Dependent is eligible to be covered under this Plan.

The eligibility date for Dependents of the Participant (as defined) shall be the earlier of: (1) the Effective Date if the Participant has Dependents on the date he or she is eligible for coverage; or (2) if a Participant acquires a Dependent after the Effective Date, the date that the individual satisfies the requirements to be a Dependent. Dependent eligibility expires concurrently with that of the Participant. Eligible persons may be covered under this Plan and become Participants subject to application to the Plan Sponsor for such coverage.

Termination: The coverage provided with respect to Covered Persons shall terminate on the earliest of the following dates: (1) The last day that the Participant satisfies all applicable eligibility requirements; or (2) The date the Plan terminates. Dependent coverage will terminate concurrently with the coverage of the Participant unless otherwise provided in the application

PART II
GENERAL PROVISIONS

YOUR RELATIONSHIP WITH THE CLAIMS ADMINISTRATOR AND THE PLAN SPONSOR: In order to make choices about your health care coverage and treatment, Plan Sponsor believes that it is important for you to understand how the Claims Administrator interacts with the Plan Sponsor's Benefit Plan and how it may affect you. The Claims Administrator helps administer the Plan Sponsor's Benefit Plan in which you are enrolled. The Claims Administrator does not provide medical services or make treatment decisions. This means:

- The Plan Sponsor and the Claims Administrator do not decide what care you need or will receive. You and your Physician make those decisions;
- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Medical Expenses, which are more fully described in this Booklet;
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Plan Sponsor and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Sponsor and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Plan Sponsor and the Claims Administrator will use de-identified data for commercial purposes including research.

THE RELATIONSHIP BETWEEN THE PLAN SPONSOR AND THE CLAIMS ADMINISTRATOR:
The Claims Administrator is not considered to be an employer or employee of the Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Plan. Plan Sponsor is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- The timely payment of Benefits; and
- Notifying you of the termination or modifications to the Plan.

RELATIONSHIP WITH PROVIDERS: The relationships between Plan Sponsor and the Claims Administrator and Preferred Providers are solely contractual relationships between independent contractors. Preferred Providers are not Plan Sponsor's agents or employees, nor are they agents or employees of the Claims Administrator. Plan Sponsor and any of its employees are not agents or employees of Preferred Providers, nor are the Claims Administrator, and any of its employees agents or employees of Preferred Providers.

Plan Sponsor and the Claims Administrator do not provide health care services or supplies, nor do they practice medicine. Instead, Plan Sponsor and the Claims Administrator arrange for health care providers to participate in a network and pay Benefits. Preferred Providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Plan Sponsor's employees nor are they employees of the Claims Administrator. Plan Sponsor and the Claims Administrator do not have any other relationship with Preferred Providers such as principal-agent or joint venture. Plan Sponsor and the Claims Administrator are not liable for any act or omission of any provider, whether they be a Preferred Provider or otherwise.

YOUR RELATIONSHIP WITH PROVIDERS: The relationship between you and any Physician, Hospital or other provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider;
- Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Covered Medical Expenses;
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- Must decide with your provider what care you should receive.

ENTIRE CONTRACT AND CHANGES: This Benefits Booklet (Booklet), including the endorsements, application, and attached papers, if any, shall constitute the entire contract between the parties. No agent has authority to change this Plan or to waive any of its provisions. No change in the Plan shall be valid until approved by an executive officer of Plan Sponsor and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Covered Person but shall be without prejudice to any claim arising prior to its effective date.

INTERPRETATION OF BENEFITS: Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to:

- Interpret Benefits under the Plan;
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this Booklet and any Endorsements and/or Amendments;
- Make factual determinations related to the Plan and its Benefits.

Plan Sponsor and the Claims Administrator may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Plan Sponsor may, in its discretion, offer Benefits for services that would otherwise not be Covered Medical Expenses. The fact that Plan Sponsor

does so in any particular case shall not in any way be deemed to require Plan Sponsor to do so in other similar cases.

FUTURE OF THE PLAN: Although Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the Termination Date, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final Benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Plan Sponsor decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Plan Sponsor and others as may be required by any applicable law.

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

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Administrator at its said office within 90 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: Benefits payable under this Plan for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any Covered Medical Expenses paid pursuant to the terms of this Plan may, at the Plan Sponsor's option, and unless the Covered Person requests otherwise in writing not later than the time of filing claims, be paid directly to the Physician, Hospital or other person rendering such service. Otherwise, owed amounts will be paid to the Covered Person or the estate of the Covered Person. Any payment so made shall discharge the Plan Sponsor's obligation to the extent of the amount of Benefits so paid.

PHYSICAL EXAMINATION: As a part of the investigation and payment of a claim, the Plan Sponsor at its own expense shall have the right and opportunity: 1) to examine the person of any Covered 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 Plan Sponsor has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Covered Person to present himself or herself for examination by a Physician when requested shall authorize the Plan Sponsor 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 Plan Sponsor has become obligated to pay to a Physician retained by the Plan Sponsor (or the Administrator on its behalf) to make an examination for which the Covered Person failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

INFORMATION AND RECORDS: Plan Sponsor and the Claims Administrator may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Plan Sponsor and the Claims

Administrator may request additional information from you to decide your claim for Benefits. Plan Sponsor and the Claims Administrator will keep this information confidential. Plan Sponsor and the Claims Administrator may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Plan Sponsor and the Claims Administrator with all information or copies of records relating to the services provided to you. Plan Sponsor and the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. No signature from any Covered Person is required indicate their acceptance of the terms of this Plan. Plan Sponsor and the Claims Administrator agree that such information and records will be considered confidential.

Plan Sponsor and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment. During and after the term of the Plan, Plan Sponsor and the Claims Administrator and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Plan Sponsor recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Claims Administrator, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Plan Sponsor and the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. the Claims Administrator's designees have the same rights to this information as does the Plan Administrator.

LAW AND LEGAL ACTIONS: This Plan is not sponsored by an employer and is not governed by the Employee Retirement Income Security Act of 1974 (ERISA). Covered Persons are not entitled to any benefits under ERISA or right to bring legal action under ERISA. No action at law or in equity, on whatever basis brought, shall be brought to recover on this Plan prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this Plan. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Plan Sponsor shall be subrogated to all rights of recovery which any Covered Person has against any person, firm or corporation to the extent of payments for Benefits made by the Plan Sponsor to, or for Benefit of, a Covered Person. The Covered Person shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Plan Sponsor.

RIGHT OF RECOVERY: Payments made by the Administrator which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Administrator from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

PART III
DEFINITIONS

ADOPTED CHILD means the adopted child placed with a Covered Person while that person is covered under this Plan. Such child will be covered from the moment of placement for the first 31 days. The Covered Person must notify the Administrator, in writing, of the adopted child not more than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Covered Person prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Covered Person's residence.

The Covered Person will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Covered Person must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Covered Person 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 date of placement.

ANCILLARY CHARGE means a charge, in addition to the Copayment and/or Coinsurance, that the Covered Person is required to pay when a covered Prescription Drug Product is dispensed at the Covered Person's or the Physician's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

BENEFITS means Plan payments for Covered Medical Expenses, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

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 are identified 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 Covered Person should know that all products identified as a "brand name" by the manufacturer, pharmacy, or a Covered Person's Physician may not be classified as Brand-name under the Plan.

CHEMICALLY EQUIVALENT means when Prescription Drug Products contain the same active ingredient.

CLAIMS ADMINISTRATOR OR ADMINISTRATOR means United HealthCare Services, Inc., and its affiliates, which provide certain claim administration services for the Plan.

COINSURANCE means the percentage of Covered Medical Expenses that you must pay.

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 Covered Person 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 Plan 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 Plan; 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 Covered Person for such services.

COVERED PERSON means either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Booklet are references to a Covered Person.

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 other section of this Plan 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 Participant's legal spouse and their dependent children by blood or by law. Dependent also means those individuals who are otherwise authorized to be Dependents by Plan Sponsor.

DESIGNATED PHARMACY means a pharmacy that has entered into an agreement with the Plan Sponsor (or the Administrator on its behalf) or with an organization contracting on the Administrator'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.

EFFECTIVE DATE means July 1, 2020, and is the date when coverage under this Plan becomes effective for Participants and their eligible Dependents. Dependent coverage will not be effective prior to that of the Participant.

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 Plan Sponsor to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means, with respect to a Medical Emergency:

1) A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the determination is made regarding coverage in a particular case, are determined to be any of the following:

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

Exceptions:

1) Clinical trials for which Benefits are specifically provided for in the Plan.
2) If the Covered Person is not a participant in a qualifying clinical trial as specifically provided for in the Plan, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment) the Administrator 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, it must first be established 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 Plan Sponsor (or the Administrator on its behalf) identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Covered Person should know that all products identified as a "generic" by the manufacturer, pharmacy or Covered Person's Physician may not be classified as a Generic under the Plan.

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

Habilitative services do not include services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment Plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment Plan, a service that was previously habilitative is no longer habilitative.

HOSPITAL means a 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 also means a licensed alcohol and drug abuse rehabilitation facility and a mental hospital. Alcohol rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises or on a prearranged basis.

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

INJURY means bodily injury which is all of the following:

1) directly and independently caused by specific accidental contact with another body or object.
2) unrelated to any pathological, functional, or structural disorder.
3) a source of loss.
4) treated by a Physician within 30 days after the date of accident.
5) sustained while the Covered Person is covered under this Plan.

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

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which Benefits are payable under this Plan.

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.

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.

MAXIMUM ALLOWABLE COST (MAC) LIST means a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to the Claims Administrator's periodic review and modification.

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

1) Death.
2) Placement of the Covered Person's health in jeopardy.
3) Serious impairment of bodily functions.
4) Serious dysfunction of any body organ or part.

5) In the case of a pregnant woman, serious jeopardy to the health of the fetus. Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

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

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

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

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

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

The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by this Plan.

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

NETWORK AREA means the 50 mile radius around the local school campus the Covered Person is attending.

NETWORK PHARMACY means a pharmacy that has:

- Entered into an agreement with the Plan Sponsor (or the Administrator on its behalf) or an organization contracting with Administrator to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Plan Sponsor (or the Administrator on its behalf) as a Network Pharmacy.

NEWBORN INFANT means any child born of a Covered Person while that person is Covered Person under this Plan. Newborn Infants will be covered under the Plan for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; Benefits will be the same as for the Covered Person who is the child's parent.

The Covered Person will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Covered Person must, within the 31 days after the child's birth: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Covered Person 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.

NEW PRESCRIPTION DRUG PRODUCT means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug

Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

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

OUT OF NETWORK means those providers who have not agreed to any prearranged fee schedules. Covered Persons may incur significant out-of-pocket expenses with these providers. Charges in excess of the amount paid by the Plan are the Covered Person's responsibility.

PARTICIPANT means an individual who meets the eligibility requirements specified in the Plan and/or the application.

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 a Covered 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.

PLAN means The Saudi Arabian Cultural Mission Student Health Plan.

PLAN ADMINISTRATOR means The Saudi Arabian Cultural Mission or its designee.

PLAN SPONSOR means The Saudi Arabian Cultural Mission.

PLAN YEAR means the period of time beginning on the Effective Date and ending June 30, 2021.

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

PREFERRED PROVIDER means the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. The Plan offers the network of Preferred Providers which is known as: **UnitedHealthcare Choice Plus PPO**. The availability of specific providers is subject to change without notice. Covered Persons should always confirm that a Preferred Provider is participating at the time services are required by calling the Administrator at 1-866-808-8461 and/or by asking the provider when making an appointment for services.

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

PRESCRIPTION DRUG COST means the rate the Plan Sponsor (or the Administrator on its behalf) 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 (PDL) means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the periodic review of Plan Sponsor (or the Administrator on its behalf) and modification (generally quarterly, but no more than six

times per calendar year). The Covered Person may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call *Customer Service* at 1-855-828-7716.

PRESCRIPTION DRUG LIST (PDL) MANAGEMENT COMMITTEE means the committee designated for, among other responsibilities, classifying Prescription Drugs into specific tiers.

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

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

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

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

SPECIALTY PRESCRIPTION DRUG PRODUCT means Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. Covered Person may access a complete list of Specialty Prescription Drug Products through the Internet at www.uhcsr.com or call *Customer Service* at 1-855-828-7716.

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

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

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

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

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

If the Covered Person has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Plan Sponsor may, in its discretion, consider an otherwise Unproven Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Plan Sponsor (or the Administrator on its behalf) 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.

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

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.

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. The Administrator uses data from FAIR Health, Inc. and Data iSight to determine Usual and Customary Charges. Usual and Customary Charges determined using data from FAIR Health, Inc. will be calculated at the 75th percentile. No payment will be made under this Plan for any expenses incurred which in the judgment of the Administrator are in excess of Usual and Customary Charges.

PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
SAUDI ARABIAN CULTURAL MISSION - STUDENT PLAN
2020-1965-1
INJURY AND SICKNESS BENEFITS

Maximum Benefit	**No Overall Maximum Dollar Limit (Per Covered Person) (Per Plan Year)**
Deductible Preferred Providers	**$0 (Per Covered Person, Per Plan Year)**
Deductible Out of Network	**$10,000 (Per Covered Person, Per Plan Year)**
Coinsurance Preferred Providers	**0% except as noted below**
Coinsurance Out of Network	**20% except as noted below**

The network for this Plan is UnitedHealthcare Choice Plus PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of Benefits. If a Preferred Provider is not available in the Network Area, Benefits will be paid at the level of Benefits shown as Preferred Provider Benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, Benefits will be paid at the Preferred Provider level of Benefits. Covered Medical Expense incurred at a Preferred Provider facility by an Out-of-Network Provider 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.

Benefits will be reimbursed at one hundred percent (100%) of billed charges under the following circumstances: 1) All Covered Medical Expenses for services rendered in Saudi Arabia; and 2) Covered Medical Expenses when due to a Medical Emergency occurring in any country outside of the United States. The Plan Deductible will not apply.

The Benefits payable are as defined in and subject to all provisions of this Plan and any endorsements thereto. Benefits are subject to the Plan Maximum Benefit unless otherwise specifically stated. 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.

Inpatient	**Preferred Provider**	**Out-of-Network Provider**
Room & Board Expense:	Preferred Allowance	Usual and Customary Charges
(Includes guest bed and meal trays for adult accompanying a minor while confined as an Inpatient.)		
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:	Preferred Allowance	Usual and Customary Charges
(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 procedure.)		
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:	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery:	Preferred Allowance	Usual and Customary Charges
(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 procedure.)		
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:	Preferred Allowance	Usual and Customary Charges
(12 visits maximum (Per Plan Year))		
Medical Emergency Expenses:	Preferred Allowance $100 Copay per visit	Usual and Customary Charges $100 Deductible per visit
(The Copay/per visit Deductible will be waived if admitted to the Hospital.) *(Benefits include the use of the Emergency Room for a non-emergency Injury or Sickness.)*		
Diagnostic X-ray Services:	Preferred Allowance	Usual and Customary Charges
Radiation Therapy:	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures:	Preferred Allowance	Usual and Customary Charges
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges
Chemotherapy:	Preferred Allowance	Usual and Customary Charges
Prescription Drugs:	UnitedHealthcare Pharmacy (UHCP) $0 Copay per prescription for Tier 1 $0 Copay per prescription for Tier 2 $0 Copay per prescription for Tier 3 up to a 31 day supply per prescription plus any Ancillary Charge *(Mail order Prescription Drugs through UHCP with a $0 Copay per prescription plus any Ancillary Charge up to a 90 day supply per prescription.)*	Usual and Customary Charges
(Ancillary Charge applies when prescription is dispensed from a higher tier at the Covered Person's request and a chemically equivalent prescription drug is available at a lower tier.)		

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services:	Preferred Allowance	Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees:	Preferred Allowance	Usual and Customary Charges
Dental Treatment:	Preferred Allowance	Usual and Customary Charges
(Includes benefits for Injury to Sound, Natural Teeth, and treatment of cleft lip and cleft palate only.)		
Mental Illness Treatment:	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment:	Paid as any other Sickness	Paid as any other Sickness
Maternity:	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services:	Preferred Allowance	Usual and Customary Charges
(Routine Children Physicals: Includes all services given in connection with the exam. Limited to 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, and 1 exam per calendar year thereafter up to age 18.)		

Other	Preferred Provider	Out-of-Network Provider
(Routine Adult Physical Exams: Includes all services given in connection with the exam. Limited to 1 exam per calendar year for adults age 18 and over.)		
(Routine Gynecological Exams: Includes all services given in connection with the exam. Limited to 1 exam and pap smear per calendar year.)		
(Mammograms: Unlimited)		
(Prostate Specific Antigen (PSA): Limited to 1 PSA test per calendar year for males age 40 and over.)		
(Digital Rectal Exam (DRE): Limited to 1 DRE per calendar year for males age 40 and over.)		
(Cancer Screening: Limited to 1 flexible sigmoidoscopy and double barium contrast every 5 years. Limited to 1 colonoscopy every 10 years for adults age 50 and over.)		
(Fecal Occult Blood Test: Limited to 1 per calendar year.)		
(Testing for Tuberculosis)		
Reconstructive Breast Surgery Following Mastectomy:	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services:	Paid as any other Sickness	Paid as any other Sickness
Home Health Care:	Preferred Allowance	Usual and Customary Charges
(Unlimited visits per Plan Year.)		
Hospice Care:	Preferred Allowance	Usual and Customary Charges
(Inpatient: 30 days lifetime maximum. Outpatient: $10,000 lifetime maximum.)		
Inpatient Rehabilitation Facility:	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility:	Preferred Allowance	Usual and Customary Charges
Urgent Care Center:	Preferred Allowance	Usual and Customary Charges
Hospital Outpatient Facility or Clinic:	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials:	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services:	Paid as any other Sickness	Paid as any other Sickness
Acupuncture in Lieu of Anesthesia:	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids:	Preferred Allowance	Usual and Customary Charges
($3,500 maximum (Per Plan Year) A written prescription is required.)		
Infertility Services:	Preferred Allowance	Usual and Customary Charges
Medical Foods:	Preferred Allowance	Usual and Customary Charges
(A written prescription is required.)		
Ostomy Supplies:	Preferred Allowance	Usual and Customary Charges
TMJ Disorder:	Preferred Allowance	Usual and Customary Charges
($5,000 maximum (Per Plan Year).)		
Repatriation:	Benefits provided by UnitedHealthcare Global or reimbursed by SACM	Benefits provided by UnitedHealthcare Global or reimbursed by SACM
Medical Evacuation:	Benefits provided by UnitedHealthcare Global	Benefits provided by UnitedHealthcare Global
Other:	Note Below	Note Below

Spinal Disorder Treatment: Preferred Allowance / Usual and Customary Charges (Caused by or related to a biochemical or nerve disorders of the spine. Unlimited visits per Plan Year). Ear Piercing provided in the Physician's office for Females age 10 and under: Preferred Allowance / Usual and Customary Charges. Treatment for Congenital Defects and Premature Born Babies: Preferred Allowance / Usual and Customary Charges. Braille Machines: Preferred Allowance / Usual and Customary Charges ($700 maximum per Plan Year). Sickle Cell Anemia Testing during Pregnancy: Preferred Allowance / Usual and Customary Charges. Obesity Treatment: Paid as any other Sickness / Paid as any other Sickness.

Other	Preferred Provider	Out-of-Network Provider
Routine Hearing Exams:	Preferred Allowance	Usual and Customary Charges

(Includes one audiometric routine exam per Plan Year.)

SHC Referral Required: Yes ( ) No (X) **Continuation Permitted:** Yes ( ) No (X)

Pre Admission Notification: Yes (X) No ( )

Other Insurance: ( ) Excess Insurance ( ) Excess Motor Vehicle (X) Primary Insurance

PART VI
PREFERRED PROVIDER INFORMATION

Regardless of the provider, each Covered Person is responsible for the payment of their Deductible. The Deductible must be satisfied before Benefits are paid. The Administrator will pay according to the Benefit limits in the Schedule of Benefits. The Preferred Provider is:

UnitedHealthcare Choice Plus PPO.

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 PPO United Behavioral Health (UBH) facilities. Call 1-866-808-8461 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. Covered Persons 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 PPO will be paid at the Coinsurance percentages specified in the Schedule of Benefits-or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the Benefit limits in the Schedule of Benefits.

PART VII
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses less any Deductible incurred by or for an Covered Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance, Copayment or per service Deductible amounts set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall be calculated on a per Covered Person Plan Year basis as stated in the Schedule of Benefits. 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:

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.

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

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

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

8. **Registered Nurse's Services.**
   Registered Nurse’s services which are all of the following:

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

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

9. **Physician's Visits (Inpatient).**
   Non-surgical Physician services when confined as an Inpatient.

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

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

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

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

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

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

15. **Physician's Visits (Outpatient).**
    Services provided in a Physician’s office for the diagnosis and treatment of a Sickness or Injury. Covered Medical Expenses also include:
    - Immunizations and Titers for infectious disease, but not if solely for your employment.
    - Allergy testing, treatment and injections.

Benefits also include the following services when performed in or provided by the Physician's office:

- Surgery.
- X-rays.
- Laboratory procedures.
- Tests and procedures.
- Supplies.

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

16. **Physiotherapy (Outpatient).**
    Includes but is not limited to the following rehabilitative services (including Habilitative Services):
    - Physical therapy.
    - Occupational therapy.
    - Cardiac rehabilitation therapy.
    - Manipulative treatment.
    - Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.

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

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

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

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

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

21. **Tests and Procedures (Outpatient).**
    Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
    - Physician's Visits.
    - Physiotherapy.
    - X-rays.
    - Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) Benefit:
- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.

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

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

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

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

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.

If more than one piece of equipment or device can meet the Covered Person's functional needs, Benefits are available only for the equipment or device that meets the minimum specifications for the Covered Person'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 Plan Year. No Benefits will be paid for rental charges in excess of purchase price.

Covered Medical Expenses Prosthetic Devices include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by Sickness, Injury, or Congenital Condition. **Covered Medical Expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis needed that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or Injury or Congenital Condition as described in the list of covered devices below for an:
- Internal body part or organ; or
- External body part.

Covered Medical Expenses also include replacement of a prosthetic device if:
- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:
- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the
- treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- any item listed in the Exclusions and Limitations section.

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

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

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

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. **Obesity Treatment.**
Benefits for obesity treatment are limited to:
- Non-surgical treatment of obesity when received by a Physician, licensed or certified dietician, nutritionist or Hospital for the following outpatient weight management services: 1) an initial medical history and physical exam; 2) diagnostic tests given or ordered during the first exam; and 3) Prescription Drugs.
- One morbid obesity surgical procedure, within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

31. **Substance Use Disorder Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

32. **Maternity.**
Same as any other Sickness. Includes private room rate.

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

34. **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. See Schedule of Benefits.

35. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy.

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

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

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

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

38. **Hospice Care.**
When recommended by a Physician for a Covered 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 Covered Person.
- Short-term grief counseling for immediate family members while the Covered Person is receiving hospice care.

39. **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.

40. **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.

41. **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.

42. **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.

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

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

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

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

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

44. **Transplantation Services.**

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

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

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

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

45. **Acupuncture in Lieu of Anesthesia.**

See Schedule of Benefits.

46. **Infertility Services.**

Benefits will be paid for infertility services as specified below.

Infertile or infertility means the condition of a presumably healthy female Covered Person who is unable to conceive or produce conception after:

- For a woman who is under 35 years of age: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination.
- For a woman who is 35 years of age or older: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Basic Infertility expenses include services or supplies rendered or provided by a Physician for the diagnosis and surgical treatment of the underlying cause of the Infertility.

To be eligible for Comprehensive Infertility and Advanced Reproductive Technology (ART) treatment, a female Covered Person must meet the following:

- The demonstrated cause of the Infertility has been recognized by a gynecologist or infertility specialist, and by the female Covered Person's Physician, and has been documented in the female Covered Person's medical records.
- The procedures are performed while the female Covered Person is not confined as an Inpatient.
- The female Covered Person's FSH levels are less than 19 miU on day 3 of the menstrual cycle.
- The Infertility is not caused by voluntary sterilization by either one of the partners (with or without surgical reversal) or by a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment.

If the female Covered Person meets the eligibility requirements above, then Comprehensive Infertility benefits shall be covered under the Plan. Comprehensive Infertility benefits include services provided by an infertility specialist. Services include:
- Ovulation induction with menotropins limited to 6 cycles per lifetime.
- Intrauterine insemination limited to 3 cycles per lifetime.

Advanced Reproductive Technology (ART) benefits include:
- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved embryo transfer.
- Intracytoplasmic sperm injection (ICSI).
- Ovum microsurgery.

To be eligible for ART benefits, the female Covered Person must meet the eligibility requirements above and:
- First exhaust the Comprehensive Infertility services benefits. Coverage for ART services is available only if the Comprehensive Infertility services do not result in a pregnancy in which a fetal heartbeat is detected.
- Be referred by the female Covered Person's Physician to the Claims Administrator for clinical review.

If the female Covered Person meets the ART eligibility requirements, then ART benefits shall be covered under the Plan. Benefits shall include:
- Up to 3 cycles of any combination of the following ART services per lifetime which only include: IVF, GIFT, ZIFT, or cryopreserved embryo transfers.
- IVF, ICSI, ovum microsurgery, GIFT, ZIFT, or cryopreserved embryo transfers.
- Charges associated with the care of a female Covered Person who is participating in a donor IVF program, including fertilization and culture.
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this Plan.

Except as specifically outlined above, Infertility services Benefits are not provided for:

- ART services for a female Covered Person attempting to become pregnant who has not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for a female under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for a female age 35 years or older).
- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal.
- Reversal of sterilization surgery.
- Infertility services for female Covered Persons with FSH levels 19 or great mIU/ml on day 3 of the menstrual cycle.
- The purchase of donor sperm and any charges for the storage of sperm.
- The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy.
- All charges associated with a gestational carrier program for the female Covered Person or the gestational carrier.
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos.
- Injectable Infertility medications, including but no limited to, menotropins, hCG, GnRH agonists, and IVIG.
- Infertility services that are not reasonably likely to result in success.
- Ovulation induction and intrauterine insemination services if the female Covered Person is not Infertile.

47. **Medical Foods.**
Benefits are payable for Medically Necessary elemental dietary enteral formulas and related supplies. Medical foods must be prescribed by a Physician. The written prescription must accompany the claim when submitted.

48. **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.

49. **Repatriation.**
If the Covered Person dies while Covered Person under the Plan; Benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. See Schedule of Benefits.

50. **Medical Evacuation.**
When Hospital Confined for at least five consecutive days and when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Covered Person to his home country. See Schedule of Benefits.

PART XIII
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 so long as information is timely received that the medical expense is due to the following:

1. Acupuncture, except as specifically provided in the Plan.

2. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
   - Nicotine addiction.

3. Behavioral problems. Conceptual handicap. Mental retardation. Intensive behavioral therapies. Milieu therapy. Parent-child problems. Applied behavioral analysis. This exclusion does not apply to:
   - Habilitative Services.
   - Developmental delay or disorder.
   - Learning disabilities.

4. Biofeedback.

5. Chronic pain disorders.

6. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which Benefits are otherwise payable under this Plan. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infant.

7. 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.

8. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - For treatment of cleft lip and cleft palate.

9. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

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

10. Health spa or similar facilities. Strengthening programs.

11. Hearing examination and hearing aids, except as specifically provided in the Plan.

12. Hirsutism. Alopecia. Hypnosis.

13. Immunizations, except as specifically provided in the Plan. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Plan.

14. Injury or Sickness for which Benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.

15. Injury or Sickness outside the United States and its possessions, except when due to a Medical Emergency. This exclusion does not apply to any services provided in Saudi Arabia.

16. Investigational services.

17. Lipectomy.

18. Marital or family counseling.

19. Methadone maintenance treatment for Substance Use Disorders.

20. Nuclear, chemical or biological Contamination, whether direct or indirect. “Contamination” means the contamination or poisoning of people by nuclear and/or chemical and/or biological substances which cause Sickness and/or death.

21. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.

22. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Plan.
    - Immunization agents, except as specifically provided in the Plan.
    - Biological sera. Blood, blood plasma, blood products, or any other blood products.
    - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs, except as specifically provided in the Plan.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Fertility agents, except as specifically provided in Infertility Services, or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

23. Reproductive/Infertility services including but not limited to the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing, except as specifically provided in the Plan.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
    - Sexual reassignment surgery.

24. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except for Covered Medical Expenses incurred in connection with participation in approved clinical trials.

25. Routine eye examinations. Eye refractions. 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 as specifically provided in the Plan.

26. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Plan.

27. Preventive care services, except as specifically provided in the Plan Schedule.

28. Services or Supplies related to birth occurring in the home or in a place not licensed to perform deliveries.

29. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis or if deemed medically necessary. This exclusion does not apply to Benefits specifically provided in the Plan.

30. Skiing. Snowboarding. Scuba diving. Surfing. Roller skating. Skateboarding. Riding in a rodeo.

31. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail Planing. Bungee jumping.

32. Sleep disorders, except when deemed medically necessary.

33. Speech therapy, except as specifically provided in the Plan. Naturopathic services.

34. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.

35. Supplies, except as specifically provided in the Plan.

36. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Plan.

37. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:
    - Motorcycle.
    - Recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle, four-wheeled all terrain vehicle (ATV), jet ski, ski cycle, or snowmobile.

38. Treatment in a Government hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.

39. 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).

40. Weight control services including surgical procedures, medical treatments, weight control/loss program, dietary regimens and supplements, food or food supplements. Exercise programs, exercise or other equipment. Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid condition. Surgery for removal of excess skin or fat. This exclusion does not apply to Benefits specifically provided in the Plan for Obesity Treatment.

PART IX
PRE-ADMISSION NOTIFICATION

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

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

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

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

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

PART X
UNITEDHEALTHCARE PHARMACY (UHCP)
PRESCRIPTION DRUG BENEFITS

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

Copayment and/or Coinsurance Amount

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

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

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

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

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 Schedule of Benefits. For a single Copayment and/or Coinsurance, the Covered Person 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 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 Plan Sponsor 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 Covered Person may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

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. The Covered Person will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug is assigned.

Ancillary Charge

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at the Covered Person's request and there is another drug that is chemically the same available at a lower tier. When the Covered Person chooses the higher tiered drug of the two, the Covered Person will pay the difference between the higher tiered drug and the lower tiered drug.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products as specified in the Plan Schedule of Benefits.

If the Covered Person requires Specialty Prescription Drug Products, the Plan Sponsor may direct the Covered Person to a Designated Pharmacy with whom the Plan Sponsor (or the Administrator on its behalf) has an arrangement to provide those Specialty Prescription Drug Products.

If the Covered Person is directed to a Designated Pharmacy and chooses not to obtain their Specialty Prescription Drug Product from a Designated Pharmacy, the Covered Person will be responsible for the entire cost of the Prescription Drug Product.
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.
Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, mail-order Pharmacy or a Designated Pharmacy.

Designated Pharmacies

If the Covered Person requires certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Plan Sponsor (or the Administrator on its behalf) may direct the Covered Person to a Designated Pharmacy with whom the Plan Sponsor (or the Administrator on its behalf) has an arrangement to provide those Prescription Drug Products.

If the Covered Person is directed to a Designated Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Pharmacy, the Covered Person will be responsible for the entire cost of the Prescription Drug Product.

Notification Requirements

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Covered Person's Physician, Covered Person's pharmacist or the Covered Person is required to notify the Plan Sponsor (or the Administrator on its behalf). The reason for notification is to determine whether the Prescription Drug Product, in accordance with 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 required notification does not occur before the Prescription Drug Product is dispensed, the Covered Person may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to periodic review and modification. The Covered Person may determine whether a particular Prescription Drug requires notification through the Internet at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

If required notification does not occur before the Prescription Drug Product is dispensed, the Covered Person can ask the Plan Sponsor (or the Administrator on its behalf) to consider reimbursement after the Covered Person receives the Prescription Drug Product. The Covered Person will be required to pay for the Prescription Drug Product at the pharmacy.

When the Covered Person submits a claim on this basis, the Covered Person may pay more because they did not notify the Administrator before the Prescription Drug Product was dispensed. The amount the Covered Person is reimbursed will be based on the Prescription Drug Cost, 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 Plan Sponsor (or the Administrator on its behalf) 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 Plan Sponsor (or the Administrator on its behalf) determines that an Covered Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Covered Person's selection of Network Pharmacies may be limited. If this happens, the Plan Sponsor (or the Administrator on its behalf) may require the Covered Person to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Covered Person uses the designated single Network Pharmacy. If the Covered Person does not make a selection within 31 days of the date the Plan Sponsor (or the Administrator on its behalf) notifies the Covered Person, the Administrator will select a single Network Pharmacy for the Covered Person.

Coverage Policies and Guidelines

The 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.

Placement of a Prescription Drug Product may be periodically changed 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 Covered Person.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered 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 Covered Person may be required to pay more or less for that Prescription Drug Product. Please access www.uhcsr.com through the Internet or call *Customer Service* at 1-855-828-7716 for the most up-to-date tier status.

Rebates and Other Payments

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

Business is conducted with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. 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. Such amounts are not passed on to the Covered Person.

Additional Exclusions

In addition to the Plan Exclusions and Limitations, 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 Plan Sponsor (or the Administrator on its behalf) to be experimental, investigational or unproven.

4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Plan Sponsor (or the Administrator on its behalf) determines do not meet the definition of a Covered Medical Expense.

5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier- 3.

7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Sponsor (or the Administrator on its behalf) 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 Plan Sponsor (or the Administrator on its behalf) 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 Plan Sponsor (or the Administrator on its behalf) 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.

9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.

10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

PART XI
CLAIM DENIALS AND APPEALS

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may contact the Claims Administrator at the number on your ID card before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim for Benefits, you or your authorized representative must submit your appeal in writing within 90 days of receiving the adverse benefit determination. This communication should include:

1. The patient's name and ID number as shown on the ID card.
2. The provider's name.
3. The date of medical service.
4. The reason you disagree with the denial.
5. Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare/StudentResources
P.O.Box 809025
Dallas, Texas 75380-9025

You do not need to submit urgent care appeals in writing. For urgent care requests for Benefits that have been denied, you or your provider can call the Claims Administrator at the number on your ID card to request an appeal.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

1. An appropriate individual(s) who did not make the initial benefit determination; or
2. A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal within 60 days from receipt of the first level appeal determination. Second level appeals will be decided by the Claims Administrator working in conjunction with the Saudi Arabian Cultural Mission.

You or your representative may request a second appeal by:

(a) if a member, contacting 866-808-8461; or
if a provider contacting 866-808-8464.

(b) sending a written request to United@moe.gov.sa which will be addressed by the Saudi Arabian Ministry of Education.

A second appeal request should include all of the following:

1. The Covered Person's name, address, and insurance ID number.
2. Your designated representative's name and address, when applicable.
3. The service that was denied.
4. Any new, relevant information that was not provided during the first level appeal.

Limitation of Action

You cannot bring any legal action to recover benefits until 90 days after you have properly submitted a request for reimbursement and all required reviews of your claim have been completed. Any legal action must be brought within two years from the expiration of the time period in which a request for reimbursement must be submitted