UNITEDHEALTHCARE INSURANCE COMPANY

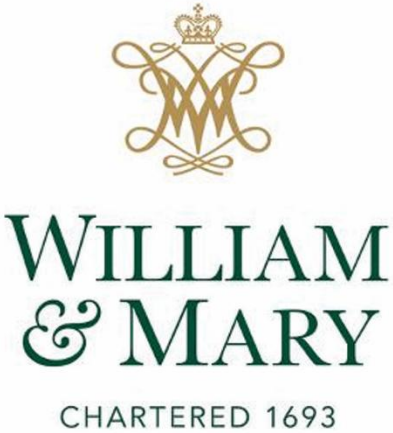
Administrative Office Address: P. O. Box 809025, Dallas, Texas 75380-9025

Home Office: Hartford, Connecticut

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for Students of



2025-2026

The Plan is Underwritten by:

UNITEDHEALTHCARE INSURANCE COMPANY

This Certificate of Coverage is Part of Policy #2025-1404-2

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

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

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

Notice: This Plan is subject to regulation by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

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Introduction

Welcome to the UnitedHealthcare Student Resources Student Health Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance Company.

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

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-800-767-0700. The Insured can also write to the Company at:

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

Section 1: Who Is Covered

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

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

All international students are eligible and are required to participate in the plan on a mandatory basis. All full-time domestic undergraduate and graduate students will be enrolled in this insurance plan and premium added to their tuition billing unless proof of comparable coverage is provided. All visiting faculty scholars and graduate research and graduate teaching assistants who are approved by the College to pursue academic work are eligible and are required to have the insurance plan unless proof of other insurance has been furnished.

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

The student (Named Insured, as defined in this Certificate) must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

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

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse or a Domestic Partner who meets the specific requirements set forth in the Definitions section of this Certificate.
   b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

Medicare Eligibility

Any person who has Medicare at the time of enrollment in this student insurance plan is not eligible for coverage under the Master Policy.

If an Insured Person obtains Medicare after the Insured Person is covered under the Master Policy, the Insured Person's coverage will not end due to obtaining Medicare.

As used here, "has Medicare" means that an individual is entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2025. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., July 31, 2026. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

If paying premiums by any payment period other than annual, such as semester, quarter, semi-annual, etc., coverage expires as follows:

Annual	08-01-25	to	07-31-26
Fall	08-01-25	to	12-31-25
Spring/Summer	01-01-26	to	07-31-26
Summer	05-01-26	to	07-31-26

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

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

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

Section 3: Extension of Benefits after Termination

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

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

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

Section 4: Pre-Admission Notification

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

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

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

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

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

Section 5: Preferred Provider and Out-of-Network Provider Information

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

Preferred Providers in the local school area are:

UnitedHealthcare Choice Plus

Preferred Provider Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities.

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

The easiest way to locate Preferred Providers is through the plan's website at www.uhcsr.com/wm. The website will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at 1-800-767-0700 for assistance in finding a Preferred Provider.

The Company arranges for health care providers to take part in the Preferred Provider network. Preferred Providers are independent practitioners. They are not employees of the Company. It is the Insured's responsibility to choose a provider. Our credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

A provider's status may change. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling Customer Service at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

1. Calling Customer Service at 1-800- 767-0700 or;
2. Logging on to the website at www.uhcsr.com/wm for information.

If an Insured receives a Covered Medical Expense from an Out-of-Network Provider and was informed incorrectly by the Company prior to receipt of the Covered Medical Expense that the provider was a Preferred Provider, either through Our provider directory or in Our response to the Insured's request for such information (via telephone, electronic, web-based or internet-based means), the Insured may be eligible for cost-sharing (Copayment, Coinsurance, and applicable Deductible) that would be no greater than if the service had been provided from a Preferred Provider.

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. An Insured may call the Company at 1-800-767-0700 to find out if they are eligible for continuity of care benefits.

If an Insured is pregnant on their Effective Date and in the first trimester of their pregnancy, the Insured must change to a Preferred Provider to have Covered Medical Expenses covered at the Preferred Provider level of benefits. If the Insured is pregnant on their Effective Date and in their second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for maternity services will be available at the Preferred Provider level of benefits even if maternity services are received from an Out-of-Network Provider. Covered Medical Expenses will include the maternity services performed by the Out-of-Network Provider through the end of the pregnancy and the normal post-partum period. An Insured may call [the Company at 1-800-767-0700 to notify the Company. Benefits will be subject to applicable cost-sharing, limitation or any other applicable provisions of the Policy.

"Preferred Provider Benefits" apply to Covered Medical Expenses that are provided by a Preferred Provider.

"Out-of-Network Provider Benefits" apply to Covered Medical Expenses that are provided by an Out-of-Network Provider.

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

Allowed Amounts are the amounts the Company will pay for Covered Medical Expenses. Refer to the definition of Allowed Amount in this Certificate for information on how the Company determines Allowed Amounts.

Preferred Provider Benefits
The Insured is not responsible for any difference between what the Company pays for Allowed Amounts and the amount the provider bills, except for the Insured Person's cost share obligation as specified in the Schedule of Benefits.

This Certificate includes the following provisions to comply with the applicable requirements of the *Consolidated Appropriations Act (the "Act") (P. L. 116 -260).* These provisions reflect requirements of the Act; however, they do not preempt applicable state law.

Out-of-Network Provider Benefits
Except as described below, the Insured Person is responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the provider bills the Insured and the amount the Company pays for Allowed Amounts.

1. For Surgical and Ancillary Services received at Preferred Provider Facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
2. For non-Surgical and non-Ancillary Services received at Preferred Provider Facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Surgical and non-Ancillary Service is provided for which notice and consent has been satisfied in accordance with applicable law, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
3. For Emergency Services provided by an Out-of-Network Provider, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's applicable Copayment, Coinsurance, or Deductible which is based on the rates that would apply if the service was provided by a Preferred Provider which is based on the Recognized Amount as defined in this Certificate.
4. For Air Ambulance services provided by an Out-of-Network Provider, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's applicable Copayment, Coinsurance, or Deductible which is based on the rates that would apply if the service was provided by a Preferred Provider which is based on the Recognized Amount as defined in this Certificate.

Please refer to the Definitions section for the definition of Facility. Standing Referrals

1. Obstetrician or Gynecologist
   Referrals are not required for any Insured female age 13 or older to receive an annual examination, and routine health care services incident to and rendered during an annual visit.
2. Specialist
   When an Insured has an ongoing special condition and the Insured receives a referral to seek treatment from a specialist for such condition, the specialist shall be permitted to treat the Insured for the special condition without further referral. The specialist may authorize such procedures, tests, referrals, and other medical services related to the Insured's special condition. A "special condition" means a condition or disease that: (i) is life-threatening, degenerative, or disabling; and (ii) requires specialized medical care over a prolonged period of time.
3. Pain Management or Oncology
   When an Insured has been diagnosed with cancer, and the Insured receives a referral to seek treatment from a board-certified physician in pain management or an oncologist, then the referral shall be in effect throughout the course of treatment for the Insured's cancer condition. This standing referral shall not be construed to authorize the board-certified physician in pain management or oncologist to direct the patient to other health care services.

Continuity of Care; Termination of Provider Contracts
In the event a contract or agreement between the Company and health care provider or provider group is terminated, a provider or provider group may be permitted to continue services for a period of at least 90 days to an Insured Person who:

1. Has an Existing Provider-Patient Relationship and who requests to continue receiving care from the provider.

2. Has been medically confirmed to be pregnant at the time of termination. Treatment may, at the Insured's option, continue through the provision of postpartum care directly related to the delivery.
3. Is determined to be terminally ill at the time of termination. Treatment shall, at the Insured's option continue for the remainder of the Insured's life for care directly related to the terminal illness.
4. Is determined to have a life-threatening condition at the time of termination, Treatment may, at the Insured's request continue for up to 180 days for care directly related to the life-threatening condition.
5. Is admitted to and receiving treatment in any Inpatient Facility at the time of termination. Treatment shall continue until the Insured Person is discharged from the Inpatient Facility.

"Existing provider-patient relationship" means the provider has rendered Covered Medical Expenses to the Insured Person or has admitted or discharged the Insured Person in the last 12 months.

The terminated provider will be the reimbursed in accordance with our agreement with the provider existing immediately before the provider's termination of network participation.

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

Section 6: Medical Expense Benefits

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

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

Benefits are payable for services delivered via Telemedicine/Telehealth. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section.

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

Inpatient

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

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

2. **Intensive Care.**
   See Schedule of Benefits.

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

   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia services rendered by an anesthesiologist.
   - Drugs (excluding take home drugs) or medicines, including injectable drugs.
   - Blood or blood products.
   - Therapeutic services, including rehabilitative and Habilitative Services.
   - Nuclear medicine.
   - Oxygen.
   - Supplies.

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

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

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

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

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

Benefits are included for angiogram, arteriogram, amniocentesis, tap or puncture of the brain or spine, arthroscopy, bronchoscopy, colonoscopy, laparoscopy, treatment of fractures and dislocation, pre-operative care, and post-operative care.

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

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

8. **Registered Nurse's Services.**
Registered Nurse's services which are all of the following:
- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

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

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

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

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

Outpatient

11. **Surgery.**
Physician's fees for outpatient surgery.

Benefits are included for angiogram, arteriogram, amniocentesis, tap or puncture of the brain or spine, arthroscopy, bronchoscopy, colonoscopy, laparoscopy, treatment of fractures and dislocation, pre-operative care, and post-operative care.

When these services are performed in a Physician's office, benefits are payable under outpatient Physician's Visits.

12. **Day Surgery Miscellaneous.**
Facility fees or charges, anesthesia agents, charges for services, and Medically Necessary medical and surgical supplies in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.

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

13. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with outpatient surgery.

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

15. **Physician's Visits.**
Services provided in a Physician's or specialist's office (including services for a second surgical opinion and services received from a nurse practitioner or other advanced practice registered nurse, clinical nurse specialist, and physician assistant), or a retail health clinic (walk-ins) for the examination, diagnosis and, treatment of a Sickness or Injury. Benefits include a Physician's visit in the Insured's home. Benefits also include online visit by webcam,, chat or voice. Benefits do not apply when related to surgery performed outside the Physician's office or Physiotherapy.

Benefits include the following services when performed in the Physician's office:
- Surgery.

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

16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services and Habilitative Services as defined in the Certificate:
- Physical therapy. Rehabilitative services provided by a licensed therapist to ease pain, restore health, and prevent disability after Sickness, Injury, or loss of limb. Services include hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices, and treatment of lymphedema. Services must include goals that are attainable in a reasonable period of time. Habilitative Services provided by a licensed therapist include therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not walking at the expected age.
- Occupational therapy. Rehabilitative services include therapy to restore activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing, and job-related activities. Services must include goals that are attainable in a reasonable period of time. Habilitative Services include therapy to keep, learn or improve skills needed for daily living such as therapy for a child who is not walking at the expected age.
- Cardiac rehabilitation therapy. Services include medical evaluation, training, supervised exercise, and psychosocial support following a cardiac event. Services will not be provided for home programs (other than Home Health Care services), on-going conditioning, and maintenance care.
- Manipulative treatment. Rehabilitative services include therapy to treat problems of the bones, joints, and back. Services must involve goals you can reach in a reasonable period of time. Benefits will end when progress towards the goal ends. Habilitative Services include therapy to treat problems of the bones, joints, and back. Services that help the Insured keep or improve skills and functioning for daily living, and includes services for people with disabilities in an Inpatient or outpatient setting.
- Speech therapy. Rehabilitative services to identify, assess, and treat speech, language, and swallowing disorders in children and adults are available. Therapy will treat communication or swallowing difficulties to correct a speech impairment. Services must include goals that are attainable in a reasonable period of time. Habilitative Services include therapy to develop communication or swallowing skills to correct a speech impairment. Services include therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age.

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

Physiotherapy provided in the Insured Person's home by a home health agency is provided as specified under Home Health Care. Physiotherapy provided in the Insured's home other than by a home health agency is provided as specified under this benefit.

See also Benefits for Early Intervention Services.

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

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

Benefits include:
- X-rays.
- Mammograms.
- Ultrasound.
- Nuclear medicine diagnostic services, including PET scans, CT scans, PET/CT Fusion scans, QTC Bone Densitometry, and CT Colonography.
- Professional services for the reading or interpretation of the images.
- CTA Scan.
- SPECT Scan.
- Magnetic Resonance Testing, including MRI, MRA and MRS.
- Nuclear Cardiology.

19. **Radiation Therapy.**
See Schedule of Benefits.

Benefits include teletherapy, brachytherapy, proton therapy, and intraoperative radiation, photon or high energy particle sources, materials and supplies, administration, treatment planning, and certain other covered services for the treatment of a Sickness by x-ray, radium, or radioactive isotopes.

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

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

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

The following tests and therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Intravenous infusion therapy.
- Pulmonary therapy, including outpatient short-term respiratory care to restore the Insured Person's health after a Sickness or Injury.

- Respiratory therapy, including the introduction of dry or moist gases into the lungs, nonpressurized inhalation treatment, intermittent positive pressure breathing treatment, air or oxygen, with our without nebulized medication, continuous positive pressure ventilation (CPAP), continuous negative pressure ventilation (CNP), chest percussion, therapeutic use of medical gases or drugs in the form of aerosols, broncho pulmonary drainage, breathing exercises, and equipment such as resuscitators, oxygen tents, and incentive spirometers to treat a Sickness or Injury.
- EKGs.
- EEGs.
- Echocardiograms.
- Dialysis, hemodialysis, and peritoneal dialysis.
- Diagnostic hearing and vision tests for a medical condition or Injury.

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

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

22. **Injections.**
When administered in the Physician's office and charged on the Physician's statement or when administered at an authorized pharmacy. Benefits include flu shot and administration. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy.**
Benefits include chemical or biological antineoplastic agents administered as part of a Physician’s visit, home care visit, or at an outpatient facility for treatment of a Sickness.

24. **Prescription Drugs.**
See Schedule of Benefits.

Other

25. **Ambulance Services.**
Benefits include Medically Necessary transportation by a state licensed vehicle that is designed, equipped, and used only to transport a sick or injured Insured Person and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals.

Ground ambulance services include transportation:
- From the Insured’s home, scene of an accident, or Medical Emergency to a Hospital.
- Between Hospitals, including when required to move from and Out-of-Network Hospital to a Preferred Provider Hospital.
- •Between a Hospital and Skilled Nursing Facility or other approved Facility.

Air or water ambulance services include transportation:
- From the scene of an accident or Medical Emergency to a Hospital.
- Between Hospitals, including when required to move from and Out-of-Network Hospital to a Preferred Provider Hospital.
- Between a Hospital and Skilled Nursing Facility or other approved Facility.

Benefits also include Medically Necessary treatment of a Sickness or Injury by medical professionals from an ambulance service, even if the Insured Person is not taken to a Facility.

Benefits are only available for Air Ambulance when it is not appropriate to use a ground or water ambulance. If using a ground ambulance would endanger the Insured Person’s health and the Insured Person’s medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, Covered Medical Expenses will include the Air Ambulance. Air Ambulance will also be covered if the Insured Person is in an area that a ground or water ambulance cannot reach.

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

26. **Durable Medical Equipment.**
Durable medical equipment must be all of the following:

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

Benefits for durable medical equipment include the rental (or purchase if less than rental) of the equipment and maintenance and necessary repairs, unless damage is due to neglect. Benefits also include supplies needed for use of the 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, which includes a composite facial prosthesis, and components that replace a limb or body part but does not include any device that is fully implanted into the body. Adjustments to the prosthetic devices are covered.
- Orthotic devices that straighten or change the shape of a body part.
- The initial purchase, fitting, adjustment, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part .
- Boots.
- Splints.
- Hospital-type beds, wheelchairs (including a battery for a powered wheelchair), and crutches.
- Oxygen concentrator, oxygen and equipment for its administration.
- Ventilator.
- Negative pressure wound therapy device.
- Nebulizers.
- Traction equipment.
- Walkers.

If more than one piece of equipment or device can meet the Insured's functional need, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year.

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

28. **Dental Treatment.**
Dental services limited to the following:
- Dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident.
- Dental appliances required to diagnose or treat an accidental Injury to the teeth, and repair of dental appliances damaged as a result of accidental Injury to the jaw, mouth, or face.
- Treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Dental services, including x-rays, extractions, and anesthesia to prepare the mouth for radiation therapy to treat cancer and prepare for transplants.
- Covered general anesthesia and hospitalization services for children under the age of 5, Insured Persons who are severely disabled, and Insured Persons who have a medical condition that requires admission to a Hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the Insured Person's treating Physician that such services are required to effectively and safely provide dental care.

An Injury resulting from chewing or biting is not covered.

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

Pediatric dental benefits are provided in the Pediatric Dental Services provision.

29. **Mental Illness Treatment.**
Benefits will be paid for services received:

- On an Inpatient basis while confined to a Hospital including Partial Hospitalization/day treatment received at a Hospital. Coverage includes Hospital and Inpatient professional charges in any Hospital or facility required by state law. Benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, and convulsive therapy.
- On an outpatient basis including outpatient facility charges, physician charges, office visits, and intensive outpatient treatment. Physician visits for medication management are covered.

See also Benefits for Mental Illness and Substance Use Disorder.

30. **Substance Use Disorder Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital. Benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, convulsive therapy, detoxification and rehabilitation. Coverage includes Hospital and Inpatient professional charges in any Hospital or facility required by state law.
- On an outpatient basis including outpatient facility charges, physician charges, office visits, and intensive outpatient treatment. Physician visits for medication management are covered.

See also Benefits for Mental Illness and Substance Use Disorder.

31. **Maternity.**
Same as any other Sickness for the Named Insured and any covered Dependent for maternity-related services, including prenatal and postnatal care.

Benefits include the following:
- Pregnancy testing.
- Maternity care and Maternity related check-ups.
- Prenatal and postnatal care.
- Services needed for a miscarriage.
- Fetal screenings for genetic and/or chromosomal status of the fetus.
- Anatomical, biochemical, or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies.
- The cost of the delivery room and care.
- Anesthesia services rendered by an anesthesiologist to provide partial or complete loss of sensation before delivery.
- Delivery by a midwife in a home setting or birthing center in lieu of an inpatient stay.
- Postpartum inpatient care and home visits in accordance with current published guidelines prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

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

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

Benefits for therapeutic abortion are provided only when the therapeutic abortion is performed:
- To save the life of the mother.
- As a result of a case of rape or incest.

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

33. **Preventive Care Services.**
Medical services, including routine physical exams, routine testing, preventive testing or treatment, and screening exams or testing in the absence of Injury or Sickness, that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Benefits include FDA-approved, cleared, or granted contraceptive drugs, devices, sterilization treatments and office visits associated with contraceptive management. Contraceptives include oral drugs, injections, patches, rings, and devices such as diaphragms, intrauterine devices (IUDs), implants and those available over-the-counter. Please see https://www.hrsa.gov/womens-guidelines for a list of contraceptives. Benefits for hormonal contraceptives will be covered for up to a 12-month supply when dispensed or furnished at one time for an Insured Person by a provider or pharmacy at a location licensed or otherwise authorized to dispense drugs or supplies. Contraceptive coverage may be excluded for certain exempt religious groups.

Required preventive care services are updated on an ongoing basis as guidelines and recommendations change. The complete list and current list of preventive care services covered under the health reform law can be found at: https://www.healthcare.gov/what-are-my-preventive-care-benefits or https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Current preventive care services are listed below.

Preventive care services for adults:

- Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have ever smoked.
- Alcohol misuse screening and counseling.
- Anxiety screening for adults age 64 years or younger, including pregnant and postpartum adults.
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 with a high cardiovascular risk.
- Behavioral counseling to promote a healthy diet and physical activity for adults age 18 and older who are at high risk of cardiovascular disease.
- Blood pressure screening for all adults.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults age 45 to 75.
- Depression screening for adults.
- Diabetes (Type 2) and prediabetes screening for adults 35 to 70 years who are overweight or obese.
- Diet/nutrition counseling for adults at higher risk for chronic disease.
- Falls prevention with exercise interventions for adults over 65, living in a community setting.
- Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
- Hepatitis C screening for adults age 18 to 79.
- HIV screening for everyone ages 15 to 65, and other ages at increased risk.
- Immunization vaccines for adults – doses, recommended ages and recommended populations vary.
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.
- Obesity screening and counseling for all adults.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use.
- Screening for unhealthy drug use in adults age 18 and older. Screening includes asking questions about unhealthy drug use, not testing of biological specimens.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Skin cancer behavioral counseling up to age 24 for adults with fair skin types.
- Statin preventive medication for adults 40 to 75 at high risk.
- Syphilis screening for all adults at higher risk for infection.
- Tobacco use screening and counseling for all adults and cessation interventions (including nicotine patches and gum when obtained with a prescription) for tobacco users.
- Tuberculosis screening for certain adults without symptoms at high risk.

Preventive care services for women:

- Anemia screening on a routine basis for pregnant women.
- Anxiety screening for pregnant and postpartum women.
- Behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause.
- Breast cancer risk assessment, genetic testing, and counseling (BRCA) for women at higher risk for breast cancer.
- Breast cancer mammography screenings every 2 years for women 40 to 74
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies and equipment, for pregnant and nursing women. Breast pumps are limited to one pump per pregnancy.
- Cervical cancer screening for women age 21 to 65.
- Chlamydia infection screening for all pregnant women, younger women, and other women at higher risk of infection.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a Physician for women with reproductive capacity (not including abortifacient drugs).
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.
- Domestic, intimate partner, and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 weeks pregnant or later and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all pregnant women, younger women, and other women at higher risk of infection.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- HIV screening and counseling for everyone age 15 to 65 and other ages at increased risk.
- Hypertensive disorder screenings with blood pressure measurements throughout pregnancy.
- Low dose aspirin after 12 weeks gestation for women who are at risk for preeclampsia.
- Maternal depression screening for mothers at well-baby visits.
- Osteoporosis screening with bone measurement for women age 65 and older.
- Osteoporosis screening with bone measurement in postmenopausal women younger than 65 who are at increased risk of osteoporosis.
- Preeclampsia prevention and screening for pregnant women with high blood pressure.
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Sexually transmitted infections screening and counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk for infection.
- Tobacco use screening and interventions for all women, and expanded intervention and counseling for pregnant tobacco users.
- Urinary incontinence screening.
- Urinary tract or other infection screening for pregnant women.
- Well-woman visits to get recommended services.

Preventive care services for children:

- Alcohol, tobacco, and drug use assessments for adolescents.
- Anxiety screening for children and adolescents ages 8 to 18 years.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Bilirubin concentration screening for newborns.
- Blood pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Blood screening for newborns.
- Depression screening for adolescents beginning routinely at age 12.
- Developmental screening for children under age 3.
- Dyslipidemia screening for children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders.

- Fluoride supplements beginning at age 6 months for children without fluoride in their water source.
- Fluoride varnish for all infants and children as soon as teeth are present.
- Gonorrhea prevention medication for the eyes of all newborns.
- Hearing screening for all newborns and regular screenings for children and adolescents as recommended by their Physician.
- Height, weight and body mass index (BMI) measurements taken regularly for all children.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for adolescents at higher risk.
- HIV screening for adolescents at higher risk.
- Hypothyroidism screening for newborns.
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary.
- Intimate partner violence screening.
- Lead screening for children at risk of exposure.
- Obesity screening and counseling for children and adolescents age 6 and older and intensive behavioral interventions to promote improvement in weight status.
- Oral health risk assessment for young children from ages 6 months to 6 years
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use.
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
- Skin cancer behavioral counseling for ages 6 months to 24 years with fair skin types.
- Syphilis screening for adolescents who are at increased risk for infection.
- Tobacco use interventions for children and adolescents, including education or brief counseling, to prevent initiation of tobacco use.
- Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Vision screening for all children.
- Well-baby and well-child visits.

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

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

Benefits will be paid for:
- Medically Necessary outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals, including pharmacies that are authorized to perform this service.
- Medical eye exams (dilated retinal exams).
- Preventive foot care for diabetes, including the care, cutting, and removal of corns, calluses, and toenails.
- Prescription Drugs (including self-injected insulin), equipment, and supplies based on the Insured's specific medical needs, including:
- Insulin pumps and supplies.
    - Home blood glucose meters including continuous glucose monitors.
    - Insulin syringes with needles.
    - Blood glucose and urine test strips.
    - Ketone test strips and tablets.
    - Lancets and lancet devices.

See also Benefits for Diabetes.

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

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

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

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

Benefits under Home Health Care also include the following:
- Physical, speech, and occupational therapy. Services provided as part of Home Health Care are not subject to separate visits limits.
- Social services.
- Diagnostic services.
- Nutritional guidance.
- Training of the patient and/or family/caregiver.
- Medical Supplies.
- Durable medical equipment.
- Remote Patient Monitoring Services.
- Medical services
- Intermittent skilled nursing services by a Registered Nurse or Licensed Practical Nurse.
- Home health aide services.

37. **Hospice Care.**

The services and supplies listed below are Covered Medical Expenses when provided for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Medical Expenses include:
- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. Coverage includes short-term Inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute Inpatient care for the Insured Person in order to provide the Insured Person's primary caregiver a temporary break from caregiving responsibilities.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a Registered Nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist. There is no therapy visit maximum applied for these services.
- Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of Insured Person's condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Insured Person's death. Bereavement services are available to surviving members of the immediate family for one year after the Insured Person's death. Immediate family means the Insured Person's spouse, children, stepchildren, parents, brothers and sisters.

Benefits for Covered Medical Expenses given for palliative care, such as chemotherapy and radiation therapy, are available to an Insured Person receiving hospice care. These additional Covered Medical Expenses are payable as indicated under other applicable sections of the Policy.
See Benefits for Hospice Care.

38. **Inpatient Rehabilitation Facility.**

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

Benefits include a day rehabilitation therapy program for Insureds who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day at a Day Hospital. Day rehabilitation program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two therapy services must be provided for this program to be a Covered Medical Expense.

39. **Skilled Nursing Facility.**
Services for convalescent care and rehabilitative care received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered in lieu of Hospital Confinement as a full-time inpatient.

Benefits include room and board, rehabilitative services, Habilitative Services, drugs, biologicals, and supplies provided during the Skilled Nursing Facility stay. Benefits also include a private room rate when Medically Necessary. There is a benefit of a minimum of 100 days per stay.

40. **Urgent Care Center.**
Often an urgent rather than an emergency health problem exists. An urgent health problem is an unexpected Sickness or Injury that calls for care that cannot wait until a regularly scheduled Physician's visit. Urgent health problems are not life threatening and do not call for the use of an emergency room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).
Benefits are limited to:
- Facility or clinic fee billed by the Urgent Care Center for the urgent care visit.
- Attending Physician's charges.
- X-rays.
- Lab services.
- Tests such as flu, urinalysis, pregnancy test, and rapid strep.
- Care for broken bones.
- Stitches for simple cuts.
- Draining an abscess.

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

41. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- Facility or clinic fee billed by the Hospital.
- Blood or blood products.

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

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

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

"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. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- 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.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (IRBs) before the Insured is enrolled in the trial. The Company may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Medical Expense and is not otherwise excluded under the Policy.

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

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

When the person donating the organ and the person receiving the transplant are both Insured Persons under the same Policy, each Insured Person will receive benefits.

When only the recipient is covered as an Insured Person, services for the donor, including complication from the donor procedures for up to 6 weeks from the date of procurement, will be covered only to the extent benefits are not available from any other source. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, grant, foundation, or any government plan that does not require the Policy to be primary.

Benefits also include:
- Necessary acquisition procedures, mobilization, harvest and storage.
- Myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

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.

Reasonable and necessary transportation and lodging expenses needed for travel of more than 75 miles from the Insured Person's permanent home may be reimbursed based on the Company's guidelines for the recipient and companion or two companions if the recipient is a minor. Reasonable and necessary transportation and lodging expenses may be reimbursed based on the Company's guidelines for the donor when the recipient and donor are covered by the Company. Benefits may be limited based on the Company's guidelines if only the recipient is covered by the Company. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

44. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the attached Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits endorsements.

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

Benefits include allergy serum, allergy shots and Physician visits for allergy shots.

46. **Dialysis.**
Benefits are limited to services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Services include dialysis treatments in an outpatient dialysis facility or a Physician's office. Services also include home dialysis and training for the Insured Person and the person who will help the Insured Person with home self-dialysis.

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

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

Benefits include Medically Necessary BRCA and fetal screenings.

48. **Hearing Aids.**
Hearing Aids for an Insured 18 years of age or younger when Medically Necessary and ordered by an otolaryngologist.

Benefits include:
- Earmolds.
- Initial batteries.
- Other necessary equipment.
- Maintenance.
- Adaptation training.

"Hearing aid" means any wearable, nondisposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords.

Benefits are limited to one Hearing Aid per hearing impaired ear every 24 months, up to $1,500 per Hearing Aid.

For the purpose of this benefit, Hearing Aids are not considered to be durable medical equipment.

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

Benefits do not include infertility treatments.

50. **Infusion Therapy.**
Benefits for the infusion therapeutic agents, medication, and nutrients delivered and administered by a health care provider as part of a doctor's visit, home care visit, or at an outpatient facility, limited to the following:
- Infusion of enteral nutrition into the gastrointestinal tract.
- Infusion of total parenteral nutrition (TPN).
- Infusion of prescription medication administered either intravenously or parenterally. This includes antibiotic therapy and pain care.
- Blood products.
- Injectables that are not self-administered.
- Chemotherapy.

Nursing services and durable medical equipment received while receiving Infusion Therapy is covered.

51. **Lymphedema**.

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

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

See also Benefits for Formula and Enteral Nutrition Products.

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

Benefits are also payable for Medically Necessary:
- Hypodermic needles and syringes.
- Supplies needed for diabetes care.
- Surgical dressings and splints.

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

54. **Oral and Maxillofacial Surgery.**
Benefits are payable for:
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveoloectomy related to a tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is Medically Necessary to attain functional capacity of the affected part.
- Surgical services to the hard or soft tissue of the mouth not related to the treatment of teeth and supporting structures.
- Surgical services to the hard or soft tissue of the mouth not related to the treatment of teeth and supporting structures.
- Cleft lip, cleft palate, or ectodermal dysplasia.
- Oral / surgical correction of accidental Injury.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

55. **Ostomy Supplies.**
Benefits for colostomy and 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.

56. **Prosthetic Devices.**
See Schedule of Benefits.

Benefits are limited to Medically Necessary prosthetic devices intended to replace, in whole or in part, an arm, hand, leg, foot, or any portion thereof. Covered devices include any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate based on the clinical assessment of the Insured's rehabilitation potential.

Benefits include the repair, fitting,adjustments, replacement, and components needed to ensure the comfort and functioning of a prosthetic device.

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

57. **Reconstructive Procedures.**
Same as any other Sickness for reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, disease, trauma or previous therapeutic process in order to create a more normal appearance.

See also Reconstructive Breast Surgery Following Mastectomy.

58. **Sleep Disorders.**
Same as any other Sickness for the Medically Necessary testing and treatment of sleep disorders when ordered by a Physician and performed in a certified sleep laboratory. Coverage includes APAP, CPAP, BPAP and oral devices.

59. **Sterilization.**
Same as any other Sickness for sterilization services and services to reverse a non-elective sterilization that resulted from Sickness or Injury.

Sterilization procedures for women for preventive care are provided as specified under Preventive Care Services.

60. **TMJ Disorders.**
Same as any other Sickness for treatment of temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Coverage includes removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Benefits do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of the teeth (fillings), crowns, bridges or dentures.

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

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

62. **Wigs.**
Wigs and other scalp hair prosthesis as a result of hair loss due to cancer. Benefits are limited to one wig per benefit period.

Section 7: Mandated Benefits

BENEFITS FOR PREGNANCY FROM RAPE OR INCEST

Benefits will be paid as for any other Injury for pregnancy resulting from an act of rape or incest.

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

BENEFITS FOR MAMMOGRAPHY

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

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

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

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

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

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

BENEFITS FOR PAP SMEARS

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

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

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

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be provided (1) for Insureds age fifty and over and (2) for Insureds age forty and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. “PSA testing” means the analysis of a blood sample to determine the level of prostate specific antigen.

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

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

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be provided for colorectal cancer screening. Coverage shall include examinations and laboratory tests and shall be provided in accordance with the most recently published recommendations established by the U.S. Preventive Services Task Force for colorectal cancer screening for which a rating of A or B is in effect with respect to the individual involved.

Benefits include:

- A follow-up colonoscopy after a positive noninvasive stool-based screening test or direct visualization screening test.
- Polyp removal and anesthesia provided in connection with a preventive screening colonoscopy.

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

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

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

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY FOLLOWING MASTECTOMY

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

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

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

BENEFITS FOR INPATIENT COVERAGE FOLLOWING MASTECTOMY

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

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

BENEFITS FOR HYSTERECTOMY

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

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

BENEFITS FOR MENTAL ILLNESS AND SUBSTANCE USE DISORDER

Benefits will be paid as specified in the Schedule of Benefits for Mental Illness and Substance Use Disorder for Medically Necessary inpatient, outpatient and Partial Hospitalization for Mental Illness and Substance Use Disorder services as follows:

1. Treatment for an adult as an Inpatient at a Hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility.
2. Treatment for a child or adolescent as an Inpatient at a Hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility.

Benefits include outpatient treatment and medication management visits for an adult, child or adolescent.

Benefits also include:

1. Diagnosis and treatment of psychiatric conditions.
2. Individual psychotherapy.

3. Group psychotherapy.
4. Psychological testing.
5. Counseling with family members to assist with the Insured's diagnosis and treatment.
6. Convulsive therapy treatment.
7. Mobile Crisis Response Services and support stabilization services provided in a Residential Crisis Stabilization Unit.

"Generally accepted standards of Mental Illness or Substance Use Disorder care" means evidence-based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties including child and adolescent psychiatry, adult psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Sources reflecting "generally accepted standards of mental health or substance use disorder care" include peer-reviewed scientific studies and medical literature, consensus guidelines and recommendations of nonprofit health care provider professional associations and specialty societies, and nationally recognized clinical practice guidelines, including patient placement criteria, service intensity assessment instruments, clinical practice guidelines, guidelines and recommendations of federal government agencies, and drug labeling approved by the U.S. Food and Drug Administration.

For the purpose of this Mandate, "Medically Necessary" means, with respect to the treatment of a Mental Illness or Substance Use Disorder, a service or product addressing the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating such disorder, including minimizing the progression of such disorder, in a manner that is in accordance with Generally Accepted Standards of Mental Illness or Substance Use Disorder care; clinically appropriate in terms of type, frequency, extent, site, and duration; and not defined primarily for the economic benefit of an insurer or purchaser or for the convenience of the patient, treating Physician, or other health care provider.

Benefits for Inpatient services for Mental Illness and Substance Use Disorder, including eating disorders, must be provided in a Hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24-hour-a-day nursing care. Residential treatment is specialized 24-hour treatment in a licensed residential treatment center or intermediate care facility. It offers individualized and intensive treatment. It includes observation and assessment by a psychiatrist at least weekly and rehabilitation, therapy, education, and recreational or social activities. Coverage includes Hospital and inpatient professional charges in any Hospital or facility required by state law. Benefits are not provided for care received from a residential treatment facility or other non-skilled, sub-acute care setting if the services are custodial, residential, or domiciliary in nature.

"Mobile crisis response services" means services licensed by the Department of Behavioral Health and Developmental Services to provide for rapid response to, assessment of, and early intervention for Insured Persons experiencing an acute mental health crisis that are deployed at the location of the Insured Person.

"Residential crisis stabilization unit" means a community-based, short-term residential program licensed by the Department of Behavioral Health and Developmental Services to provide short-term assessment, observation, support, and crisis stabilization for the Insured Person who is experiencing an acute mental health crisis.

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

BENEFITS FOR DIABETES

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

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

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

BENEFITS FOR CLINICAL TRIALS FOR TREATMENT STUDIES ON CANCER

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

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

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

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

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

This benefit shall apply only if all the following apply:

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

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

BENEFITS FOR PRESCRIPTIONS FOR CANCER PAIN IN EXCESS OF RECOMMENDED DOSAGE

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

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

BENEFITS FOR PRESCRIPTION DRUGS FOR CANCER TREATMENT AND TREATMENT OF A COVERED INDICATION

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

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

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

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

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical

journals. Peer-reviewed medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

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

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

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

BENEFITS FOR HOSPICE CARE

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

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

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

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

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

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

BENEFITS FOR HOME TREATMENT OF HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS

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

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

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

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

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

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

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

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

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

BENEFITS FOR EARLY INTERVENTION SERVICES

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

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

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

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

BENEFITS FOR NEWBORN INFANT HEARING SCREENING

Benefits will be provided for newborn infant hearing screenings and all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recommended by the National Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such benefits shall include any follow-up audiological examinations as recommended by a Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.
Newborn infant hearing screenings covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

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

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

BENEFITS FOR ROUTINE AND NECESSARY CHILDHOOD IMMUNIZATIONS

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

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

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

Childhood immunizations not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

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

BENEFITS FOR GENERAL ANESTHESIA AND HOSPITALIZATION FOR DENTAL CARE

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

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

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

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

BENEFITS FOR ORALLY ADMINISTERED CANCER CHEMOTHERAPY DRUGS

Benefits will be paid for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy; provided that the Copayment, Coinsurance, and Deductibles are at least as favorable to an Insured Person as the Copays, Coinsurance or Deductibles that apply to intravenous or injected anticancer medications.

BENEFITS FOR AUTISM SPECTRUM DISORDER

Benefits will be paid the same as any other Mental Illness for the Diagnosis of Autism Spectrum Disorder and the Treatment of Autism Spectrum Disorder.

"Autism Spectrum Disorder" means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Diagnosis of Autism Spectrum Disorder" means assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.

"Medically necessary," for the purpose of this benefit, means in accordance with the generally accepted standards of mental disorder or condition. care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following:

1. Prevent the onset of a Sickness, condition, Injury, or disability.
2. Reduce or ameliorate the physical, mental, or developmental effects of a Sickness, condition, Injury, or disability.
3. Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Insured and the functional capacities that are appropriate for the Insured.

“Treatment of Autism Spectrum Disorder” shall be identified in a treatment plan and includes the following care prescribed or ordered by a Physician or psychologist who determines the care to be Medically Necessary for an Insured diagnosed with Autism Spectrum Disorder:

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

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

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

BENEFITS FOR FORMULA AND ENTERAL NUTRITION PRODUCTS

Benefits will be paid the same as any other Prescription Drug for Medically Necessary Formula and Enteral Nutrition Products.

“Inherited metabolic disorder” means an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

“Medically necessary formula and enteral nutrition products" means any liquid or solid formulation of formula and enteral nutrition products for Insureds requiring treatment for an Inherited Metabolic Disorder. The Insured’s Physician is to issue a written order stating that the formula or enteral nutrition product is Medically Necessary, has been proven effective as a treatment regimen for the Insured, and that it is a critical source of nutrition as certified by the Physician by diagnosis. The Medically Necessary formula or enteral products do not need to be the Insured's primary source of nutrition.

Benefits include:

1. Partial or exclusive feeding by means of oral intake or enteral feeding by tube.
2. Medical equipment, supplies, and services that are required to administer the Medically Necessary Formula or Enteral Nutrition Products.
3. Medically Necessary Formula and Enteral Nutrition Products that are furnished pursuant to the prescription or order of a Physician and used under medical supervision, which may include a home setting.

Benefits do not include nutritional supplements taken electively.

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

BENEFITS FOR TREATMENT OF GENDER DYSPHORIA

Benefits will be paid the same as any other Sickness for treatment of gender dysphoria for Medically Necessary Transition-Related Care.

"Medically necessary transition-related care" means any medical treatment prescribed by a licensed Physician for treatment of gender dysphoria and includes:

1. Outpatient psychotherapy and mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses;
2. Continuous hormone replacement therapy;
3. Outpatient laboratory testing to monitor continuous hormone therapy.
4. Gender reassignment surgeries.

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

Section 8: Coordination of Benefits Provision

Benefits will be coordinated with any other eligible medical, surgical, or hospital Plan or coverage so that combined payments under all programs will not exceed 100% of Allowable Expenses incurred for covered services and supplies.

Definitions

1. **Allowable Expenses:** Any health care expense, including Coinsurance, or Copays and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health Plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health Plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.
   - The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.
   - For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
   - For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
   - If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

The amount of any benefit reduction by the Primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admission, and Preferred Provider arrangements.

2. **Plan:** A form of coverage with which coordination is allowed.

   Plan includes all of the following:
   - Group insurance contracts and subscriber contracts.
   - Uninsured arrangements of group or group-type coverage.
   - Group coverage through closed panel Plans.
   - Group-type contracts, including blanket contracts.
   - The medical care components of long-term care contracts, such as skilled nursing care.

- Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of Plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

Plan does not include any of the following:

- Hospital indemnity coverage benefits or other fixed indemnity coverage.
- Accident only coverage.
- Limited benefit health coverage as defined by state law.
- Specified disease or specified accident coverage.
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
- Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
- Medicare supplement policies.
- State Plans under Medicaid.
- A governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other nongovernmental Plan.
- An Individual Health Insurance Contract.

3. **Primary Plan:** A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.

4. **Secondary Plan:** A Plan that is not the Primary Plan.

5. **We, Us or Our:** The Company named in the Policy.

Rules for Coordination of Benefits - When an Insured Person is covered by two or more Plans, the rules for determining the order of benefit payments are outlined below.

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan.

A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary. This does not apply to coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Plan to provide out of network benefits.

If the Primary Plan is a closed panel Plan and the Secondary Plan is not a closed panel Plan, the Secondary Plan shall pay or provide benefits as if it were the Primary Plan when an Insured Person uses a non-panel provider, except for Emergency Services or authorized referrals that are paid or provided by the Primary Plan.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Order of Benefit Determination - Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent/Dependent.** The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing

regulations, Medicare is both (i) secondary to the Plan covering the person as a dependent; and (ii) primary to the Plan covering the person as other than a dependent, then the order of benefit is reversed. The Plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

2. **Dependent Child/Parents Married or Living Together.** When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:
   - The benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
   - However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

3. **Dependent Child/Parents Divorced, Separated or Not Living Together.** If two or more Plans cover a person as a Dependent child of parents who are divorced or separated or are not living together, whether or not they have ever been married, benefits for the child are determined in this order:

   If the specific terms of a court decree state that one of the parents is responsible for the health care services or expenses of the child and that Plan has actual knowledge of those terms, that Plan is Primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's Plan is the Primary Plan. This item shall not apply with respect to any Plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

   If a court decree states that both parents are responsible for the child's health care expenses or coverage, the order of benefit shall be determined in accordance with part (2).

   If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the order of benefits shall be determined in accordance with the rules in part (2).

   If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:
   - First, the Plan of the parent with custody of the child.
   - Then the Plan of the spouse of the parent with the custody of the child.
   - The Plan of the parent not having custody of the child.
   - Finally, the Plan of the spouse of the parent not having custody of the child.

4. **Dependent Child/Non-Parental Coverage.** If a Dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as if those individuals were parents of the child.

5. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   - First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
   - Second, the benefits under the COBRA or continuation coverage.
   - If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

If none of the provisions stated above determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on Benefits - When Our Plan is secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to the Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

Right to Recovery and Release of Necessary Information - For the purpose of determining applicability of and implementing the terms of this provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery - Whenever payments which should have been made under our coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

Section 9: Accidental Death and Dismemberment Benefits

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

For Loss Of

Life	$1,000.00
Two or More Members	$1,000.00
One Member	$ 500.00

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

Section 10: Student Health Center (SHC) Referral Required

STUDENTS ONLY
OUTPATIENT SERVICES ONLY
The student must use the services of the Health Center first where outpatient treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

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

1. Medical Emergency. The student must return to SHC for necessary follow-up care.
2. When the Student Health Center is closed.
3. When service is rendered at another facility during break or vacation periods.
4. Medical care received when the student is more than 10 miles from campus.
5. Medical care obtained when a student is no longer able to use the SHC due to a change in student status.
6. Maternity, obstetrical and gynecological care.
7. Mental Illness treatment and Substance Use Disorder treatment.

Dependents are not eligible to use the SHC and therefore are exempt from the above limitations and requirements.

Section 11: Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student policy for at least 3 consecutive months and who no longer meet the eligibility requirements under that policy are eligible to continue their coverage for a period of not more than 6 months under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

Application must be made and premium must be paid directly to UnitedHealthcare Student Resources and be received within 31 days after the expiration date of the Insured's coverage. For further information on the Continuation Privilege, please contact UnitedHealthcare Student Resources.

Section 12: Definitions

ADOPTED OR NEWBORN CHILD means:

1. A newly born child of the Insured from the moment of birth provided that person is insured under this Policy.
2. A child adopted by the Insured provided the person adopting the child is insured under this Policy on the date the adoption becomes effective.
3. A child who has been placed for adoption with the Insured provided the person adopting the child is insured under the Policy on the date the child is placed with the Insured.

Such child will be covered under the Policy for the first 31 days after:

- Birth of the newly born child.
- The effective date of adoption of the child.
- The date of placement of the child for adoption, unless the placement is disrupted prior to final decree of adoption, and the child is removed from placement with the Insured.

Coverage for such a child will be for Injury or Sickness, including medically diagnosed Congenital Conditions, birth abnormalities, prematurity, nursery care; inpatient and outpatient dental services and dental appliances, oral surgical services, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia. Benefits will be the same as for the Insured Person who is the child's parent.

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

AIR AMBULANCE means medical transport by rotary wing air ambulance or fixed wing air ambulance as defined in *42 CFR 414.605*.

ALLOWED AMOUNT means the maximum amount the Company is obligated to pay for Covered Medical Expenses. Allowed amounts are determined by the Company or determined as required by law, as described below.

Allowed amounts are based on the following:

When Covered Medical Expenses are received from a Preferred Provider, allowed amounts are the Company's contracted fee(s) with that provider.

When Covered Medical Expenses are received from an Out-of-Network Provider as described below, allowed amounts are determined as follows:

1. **For non-Medical Emergency Covered Medical Expenses received at Preferred Provider facilities from Out-of-Network Provider Physicians** when such services are either: a) Surgical and Ancillary Services; or b) non-Surgical and non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary, the allowed amount is based on one of the following in the order listed below as applicable:
   - The reimbursement rate as determined by a state *All Payer Model Agreement*.
   - The reimbursement rate as determined by state law.

- The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
- The amount determined by *Independent Dispute Resolution (IDR)*.

2. **For Emergency Services provided by an Out-of-Network Provider**, the allowed amount is based on one of the following in the order listed below as applicable:
   - The reimbursement rate as determined by a state *All Payer Model Agreement*.
   - The reimbursement rate as determined by state law.
   - The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
   - The amount determined by *Independent Dispute Resolution (IDR)*.

3. **For Air Ambulance transportation provided by an Out-of-Network Provider**, the allowed amount is based on one of the following in the order listed below as applicable:
   - The reimbursement rate as determined by a state *All Payer Model Agreement*.
   - The reimbursement rate as determined by state law.
   - The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
   - The amount determined by *Independent Dispute Resolution (IDR)*.

When Covered Medical Expenses are received from an Out-of-Network Provider, except as described above, allowed amounts are determined based on either of the following:

1. Negotiated rates agreed to by the Out-of-Network Provider and either the Company or one of Our vendors, affiliates or subcontractors.
2. If rates have not been negotiated, then one of the following amounts:
   - Allowed amounts are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographical market, with the exception of the following.
     - 50% of CMS for the same or similar freestanding laboratory service.
     - 45% of CMS for the same or similar Durable Medical Equipment from a freestanding supplier, or CMS competitive bid rates.
     - 70% of CMS for the same or similar physical therapy service from a freestanding provider.
   - When a rate for all other services is not published by CMS for the service, the allowed amount is based on 20% of the provider's billed charge.

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically put in place within 30 to 90 days after CMS updates its data.

For Covered Medical Expenses related to surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services received at a Preferred Provider Facility on a non-Medical Emergency basis from an Out-of-Network Provider Facility based Physician, the allowed amount is based on the commercially reasonable rate, which is defined as the median amount negotiated with Preferred Providers for the same service or similar service provided in a similar geographic area.

Out-of-Network Provider Facility based Physicians may not bill the Insured for any difference between the Physician's billed charge and the allowed amount described here.

For Emergency Services provided by an Out-of-Network Provider, the allowed amount is a rate agreed upon by the Out-of-Network Provider or the commercially reasonable rate, which is defined as the median amount negotiated with the Preferred Providers for the same service or similar service provided in a similar geographic area. Out-of-Network Providers may not bill the Insured for any difference between the provider's billed charges and the allowed amount described here.

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

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

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

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

COVERED MEDICAL EXPENSES means health care services and supplies which are all of the following:

1. Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness or Injury.
2. Medically Necessary.
3. Specified as a covered medical expense in this Certificate under the Medical Expense Benefits or in the Schedule of Benefits.
4. Not in excess of the Allowed Amount or the Recognized Amount when applicable.
5. Not in excess of the maximum benefit payable per service as specified in the Schedule of Benefits.
6. Not excluded in this Certificate under the Exclusions and Limitations.
7. In excess of the amount stated as a Deductible, if any.

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

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance with activities of daily living, including eating, dressing, bathing, transferring, and ambulating.
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.

DAY HOSPITAL means a facility that provides day rehabilitation services on an outpatient basis.

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

DEPENDENT means the legal spouse or Domestic Partner of the Named Insured and their dependent children, which includes any son, daughter, stepchild, adopted child, child placed for adoption, foster child, or any child for whom the Insured must provide coverage due to court order. Children shall cease to be dependent at the end of the enrollment period in which they attain the age of 26 years.

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

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

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

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who:

1. Is the Named Insured’s sole spousal equivalent.
2. Lives together with the Named Insured in the same residence and intends to do so indefinitely.
3. Is responsible with the Named Insured for each other’s welfare.

A domestic partner relationship may be demonstrated by any three of the following types of documentation:

1. A joint mortgage or lease.
2. Designation of the domestic partner as beneficiary for life insurance.
3. Designation of the domestic partner as primary beneficiary in the Named Insured’s will.

4. Domestic partnership agreement.
5. Powers of attorney for property and/or health care.
6. Joint ownership of either a motor vehicle, checking account or credit account

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

EMERGENCY SERVICES with respect to a Medical Emergency, means:

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition.
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 or an Independent Freestanding Emergency Department to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)*).
3. With respect to Mental Illness or Substance Use Disorder, Covered Medical Expense rendered at a behavioral health crisis service provider:
   a. A behavioral assessment that is within the capability of a behavioral health crisis service provider, including ancillary services routinely available to evaluate such emergency medical condition.
   b. Such further examination and treatment, to the extent that they are within the capabilities of the staff and facilities available at the behavioral health crisis service provider, as required so that the Insured's condition does not deteriorate.

   Emergency services include items and services otherwise covered under the Policy when provided by an Out-of-Network Provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient stay or outpatient stay that is connected to the original emergency medical condition, unless the attending Physician or treating provider for the Medical Emergency determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available Preferred Provider or Preferred Provider Facility located within a reasonable distance taking into consideration the patient's medical condition.

FACILITY means an institution providing health care related services or a health care setting, including but not limited to: 1) Hospitals and other licensed Inpatient centers; 2) ambulatory surgical or treatment centers; 3) skilled nursing centers; 4) residential treatment centers; 5) diagnostic, laboratory and imaging centers; and 6) rehabilitation and other therapeutic health settings.

GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Company has the right to seek expert opinion in determining whether services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use such expert opinion shall be determined by the Company.

The Company develops and maintains clinical policies that describe the generally accepted standards of medical practice scientific evidence, prevailing medical standards, and clinical guidelines supporting the Company's determinations regarding specific services. These clinical policies are available through [UHCprovider.com].

HABILITATIVE SERVICES means coverage for health care services that help a person keep, learn, or improve skills and functioning for daily living. This includes services for people with disabilities in an Inpatient or outpatient setting.

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

HOSPITAL means a licensed or properly accredited general hospital which is all of the following:

1. Open at all times.
2. Operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients.
3. 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.
6. Not primarily a clinic, nursing, rest or convalescent home.

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

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

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT means a health care facility that: 1) is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and 2) provides Emergency Services.

INJURY means bodily injury which is all of the following:

1. Directly and independently caused by specific accidental contact with another body or object.
2. Unrelated to any pathological, functional, or structural disorder.
3. A source of loss.
4. Treated by a Physician within 30 days after the date of accident.
5. Sustained while the Insured Person is covered under the Policy.

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

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

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

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

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

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

MEDICAL EMERGENCY means, regardless of the final diagnosis rendered to an Insured, a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention would result in any of the following:

1. Serious jeopardy to the mental or physical health of the Insured.
2. Danger of serious impairment of bodily functions.
3. Serious dysfunction of any bodily organ or part.
4. In the case of a pregnant woman, serious jeopardy to the health of the woman or unborn child.

Expenses incurred for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

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 Generally Accepted Standards of Medical Practice.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.
5. The most clinically appropriate supply, frequency, duration, or level of service which can safely be provided to the Insured.

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

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

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

MEDICARE means Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

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 Mental Disorders published by the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense.

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

OUT-OF-NETWORK PROVIDER means a provider who does not have a contract with the Company to provide services to Insured Persons.

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

PARTIAL HOSPITALIZATION means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for Insureds with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to Insureds who are not admitted on an inpatient basis. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to Insureds who are not admitted on an inpatient basis.

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

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

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

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

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

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

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

PREFERRED PROVIDER means a provider that has a participation agreement in effect (either directly or indirectly) with the Company or Our affiliates to participate in Our preferred provider network. Our affiliates are those entities affiliated with the Company through common ownership or control with Us or with Our ultimate corporate parent, including direct and indirect subsidiaries.

PRESCRIPTION DRUGS means any of the following:

1. Prescription legend drugs.
2. Compound medications of which at least one ingredient is a prescription legend drug.
3. Any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician.
4. Injectable insulin.

RECOGNIZED AMOUNT means the amount which any Copayment, Coinsurance, and applicable Deductible is based on for the below Covered Medical Expenses when provided by Out-of-Network Providers:

1. Out-of-Network Emergency Services.
2. Non-Emergency Services received at Preferred Provider Facilities by Out-of-Network Provider Physicians, when such services are either Surgical and Ancillary Services or non-Surgical and non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*.

The amount is based on one of the following in order listed below as applicable:

1. An *All Payer Model Agreement* if adopted.
2. State law.
3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The recognized amount for Air Ambulance services provided by an Out-of-Network Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Medical Expenses that use the recognized amount to determine the Insured's cost sharing may be higher or lower than if cost sharing for these Covered Medical Expenses were determined based on an Allowed Amount.

For Emergency Services provided by an Out-of-Network Provider and for non-Emergency Services provided to an Insured at a Preferred Provider Facility by an Out-of-Network Provider, the Allowed Amount is a rate agreed upon by the Out-of-Network Provider or the commercially reasonable rate, which is defined as the median amount negotiated with Preferred Providers for the same service or similar service provided in a similar geographic area.

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

SECRETARY means the term secretary as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

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

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

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

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

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense.

SURGICAL AND ANCILLARY SERVICES means items and any professional services provided by Out-of-Network Provider Physicians at a Preferred Provider Facility including, but not limited to:

1. Emergency medicine, anesthesiology, pathology, radiology, and neonatology.
2. Provided by assistant surgeons, hospitalists, and internists.
3. Diagnostic services, including radiology and laboratory services.
4. Provided by such other specialist practitioners as determined by the Secretary.

TELEHEALTH/TELEMEDICINE means live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as an Insured Person's home or place of work.

Telemedicine services also include use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating an Insured, providing remote patient monitoring services, or consulting with other health care providers regarding an Insured's diagnosis or treatment, regardless of the originating site and whether the Insured is accompanied by a health care provider at the time such services are provided.

Telemedicine services do not include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

URGENT CARE CENTER means a licensed health care entity that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Section 13: Exclusions and Limitations

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

1. Acupuncture.
2. Behavioral problems. Developmental delay or disorder or intellectual disability. Learning disabilities. Parent-child problems.
   This exclusion does not apply to conditions classified as a Mental Illness or Substance Use Disorder in the *Diagnostic and Statistical Manual of the American Psychiatric Association* or except as specifically provided in the Policy.
3. Cosmetic procedures, except as specifically provided in the Policy for Reconstructive Procedures.
4. Dental treatment, except:
   - As provided in the Dental Treatment benefit.
   - As specifically provided in the Schedule of Benefits.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
5. Elective Surgery or Elective Treatment as defined in the Policy.
6. Elective abortion. This exclusion does not apply to therapeutic abortion as specifically provided in the Policy under Maternity Benefits.
7. 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 routine or preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease

8. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
   This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of a Congenital Condition, infection, or Injury.
   - Benefits specifically provided in Benefits for Newborn Infant Hearing Screening, Benefits specifically provided in Benefits for Hearing Aids and Related Services.
9. Hirsutism. Alopecia.
10. Immunizations for travel or work.
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
12. Lipectomy.
13. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.
14. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
    - Immunization agents, except as specifically provided in the Policy.
    - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Fertility agents.
    - Growth hormones.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
15. Reproductive services for the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing, except as specifically provided in Genetic Testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
    - Premarital examinations.
    - Reversal of sterilization procedures, except as specifically provided in the Policy under Sterilization.
    - Impotence, organic or otherwise.
16. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To eyeglasses or contact lenses as described under Vision Correction in the Policy.
    - To benefits specifically provided in the Schedule of Benefits.
17. Routine Adopted or Newborn Child Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
18. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
19. 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.
20. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Benefits for Reconstructive Breast Surgery Following Mastectomy..
21. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

22. 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).
23. Weight management. Weight reduction. Treatment for obesity (except morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Schedule of Benefits.

Section 14: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Center or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2. Insureds can submit claims online in their My Account at www.uhcsr.com/MyAccount or submit claims by mail. If submitting by mail, send to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the college under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within 15 months of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

If submitting a claim by mail, send the above information to the Company at:

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

Section 15: General Provisions

GRACE PERIOD: A grace period of thirty-one days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Policyholder has given the Company written notice of discontinuance of the Policy in accordance with the terms of the Policy and in advance of the date of discontinuance.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy. Failure to give notice within that time shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to the Company 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: Indemnities payable under the Policy for any loss will be paid within 30 days after receipt of due written proof of such loss.

PAYMENT OF CLAIMS: Indemnities payable under the Policy for any loss will be paid within 60 days after receipt of due written proof of such loss, unless otherwise required by the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260).

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

Indemnities provided under the Policy for any of the Out-of-Network Provider services listed in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* will be paid directly to the Provider.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law.

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

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear. This provision in no way intends to secure subrogation rights for the Company against a third party.

INCONTESTABILITY: The validity of the Policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. The Company reserves the right to contest the validity of the Policy for up to two years from its date of issue. No statement made by any person insured under the Policy relating to his insurability or the insurability of his insured Dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1) after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2) unless the statement is contained in a written instrument signed by him. This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

FRAUD OR INTENTIONAL MISREPRESENTATION OF A MATERIAL FACT: The Company will provide at least 30 days advance written or electronic notice to the Insured that coverage will end on the date We identify in the notice because the Insured committed an act, practice or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to an Insured Person’s eligibility.

We will provide at least 30 days prior written notice of when coverage ends. Such notice will include:

- Clear identification of the alleged fraudulent act, practice or omission, or an intentional misrepresentation of a material fact.
- An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact.
- Notice that the Insured or Insured’s authorized representative, prior to the date the advanced notice ends, may immediately file an internal appeal to request reconsideration.
- A description of our internal appeal process, including any time limits applicable to those procedures.
- The date when the advance notice ends and the date back to which the coverage ends.

The Insured has a right to a refund of all premiums less any claims paid beyond the date on which coverage ends.

The Insured is responsible for paying the Company for the cost of previously received services based on the Allowed Amount, when applicable, for such services, less any Copayment made or premium paid for such services.

Section 16: Notice of Appeal Rights

What to Do if the Insured Person Has a Question

Call the telephone number shown on the Insured Person’s ID card. Representatives are available to take the Insured Person’s call during regular business hours, Monday through Friday.

What to Do if the Insured Person Has a Complaint

Call the telephone number shown on the Insured Person’s ID card. Representatives are available to take the Insured Person’s call during regular business hours, Monday through Friday.

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

If the representative cannot resolve the issue over the phone, he/she can help the Insured Person prepare and submit a written complaint. The Company will notify the Insured Person of our decision regarding the complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

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

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

How to Request an Appeal

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

The request for an appeal should include:

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

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Company may consult with, or ask medical experts as part of the appeal process. The Insured Person consents to this referral and the sharing of needed medical claim information. Upon request and free of charge, the Insured Person has the right to reasonable access to and copies of all documents, records and other information related to the claim for benefits. In addition, if any new or additional evidence is relied upon or generated by the Company during the determination of the appeal, the Company will provide it free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

For procedures related to urgent requests for benefits, see *Urgent Appeals that Require Immediate Action* below.

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

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

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

The second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will take place and the Insured Person will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

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

Concurrent Review Requests

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

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

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

- We will provide the Insured Person with a written or electronic determination within 72 hours following receipt of the request for review of the determination, taking into account the seriousness of the Insured's condition.
- If the Company needs more information from the Insured Person or the Insured Person's Physician to make a decision, the Company will notify the Insured Person or the Insured Person's Physician as soon as possible, but not later than 24 hours after receipt of the request, of the specific information necessary to complete the review. The Insured Person or the Insured Person's Physician will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the requested information. The Company will notify the Insured Person and the Insured Person's Physician of the decision not later than 48 hours after the earlier of 1) the Company's receipt of the specified information or 2) the end of the period afforded to provide the requested information. The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.
- For all other non-urgent review requests, see Pre-service Requests for Benefits and Post-service Claim Appeals above.

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

Urgent Appeals that Require Immediate Action

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

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

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

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

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

Exhaustion of Internal Appeal Process

The Insured Person must exhaust the internal appeal process before submitting a request for external review as described below under *Virginia External Review Program*. An Insured Person is not required to exhaust the internal appeal process before seeking an external review of an adverse determination relating to the treatment of cancer. The internal appeal process is considered exhausted when:

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

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

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

Office of the Managed Care Ombudsman
P.O. Box 1157
Richmond, VA 23218
Telephone: (877) 310-6560
Fax: (804) 371-9944
E-mail: Ombudsman@scc.virginia.gov

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

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

Virginia External Review Program

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

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

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

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

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

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

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

- The Insured Person did not receive a decision from the Company within the required time frame concerning a standard internal appeal.
- The Company waived the requirement to exhaust the internal appeal process.
- In the case of an expedited external review request, for the reasons described below under *Expedited External Review*.

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

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

Standard External Review

A standard external review includes all of the following:

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

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

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process. An Insured Person is not required to exhaust the internal appeal process before seeking an external review of an adverse determination relating to the treatment of cancer.
- Has provided all the information and forms required so that the Company may process the request.

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

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

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

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

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

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

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

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances the Insured Person may file an expedited external review before completing the internal appeals process. An Insured Person is not required to exhaust the internal appeal process before seeking an external review of an adverse determination relating to the treatment of cancer.

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

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves cancer or a medical condition for which the time frame for completion of an urgent internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and the Insured Person has filed a request for an urgent internal appeal.
- A final appeal decision, if the determination involves cancer or a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care,

continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

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

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

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

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

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

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

Section 17: Online Access to Account Information

UnitedHealthcare Student Resources Insureds have online access to claims status, EOBs, ID cards, network providers, correspondence, and coverage information by logging in to My Account at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "Create Account" link. Follow the simple, onscreen directions to establish an online account in minutes using the Insured's 7-digit Insurance ID number or the email address on file.

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

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

Section 18: ID Cards

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

Section 19: UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating healthcare or Mental Health providers, find contact information for the provider's office or facility, and locate the provider's office or facility on a map.

- Find My Claims – view claims received within the past 120 days for both the primary Insured and covered Dependents; includes provider, date of service, status, claim amount and amount paid.

Section 20: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700
Website:www.uhcsr.com/wm

Sales/Marketing Services:
UnitedHealthcare Student Resources
11399 16th Court North, Suite 110
St. Petersburg, FL 33716
Email: info@uhcsr.com

Customer Service:
800-767-0700
(Customer Services Representatives are available Monday - Friday, 7:00 a.m. – 7:00 p.m. (Central Time))

UNITEDHEALTHCARE INSURANCE COMPANY

Schedule of Benefits

William & Mary
2025-1404-2
METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 87.060%
Injury and Sickness Benefits

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

Deductible Preferred Provider	$150 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$300 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% of Allowed Amount, except as noted below
Coinsurance Out-of-Network Provider	50% of Allowed Amount, except as noted below
Out-of-Pocket Maximum Preferred Provider	$7,350 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	$14,700 (For all Insureds in a Family, Per Policy Year)

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

The **Preferred Provider** for this plan UnitedHealthcare Choice Plus.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. “Network area” means the 10 mile radius around the local school campus the Named Insured is attending.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider. Refer to the *Preferred Provider and Out-of-Network Provider Information* section of the Certificate for information on reimbursement for Emergency Services provided by an Out-of-Network Provider, Covered Medical Expenses provided at certain Preferred Provider facilities by an Out-of-Network Physician, and Air Ambulance transport provided by an Out-of-Network Provider.

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

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

Student Health Center Benefits:

1. The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center for the following services: Outpatient Physician's Visits.
2. The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center for the following services:
   a) Prescription Drugs after a $5 Copay per prescription for generic and $15 Copay per prescription for brand-name drugs, up to a 31-day supply per prescription.
   b) Laboratory Procedures after a $10 Copay per visit; and
   c) All other services listed in the Schedule of Benefits.
3. The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at or referred by the Student Health Center for the following services: Laboratory services at LabCorp after a $10 Copay per visit.

Out-of-Country Claims: Covered Medical Expenses incurred outside the United States will be paid at 80% of the Allowed Amount.

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

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	$250 Copay per Hospital Confinement Allowed Amount after Deductible	$250 Copay per Hospital Confinement Allowed Amount after Deductible
Intensive Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Miscellaneous Expenses	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Registered Nurse's Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	Allowed Amount after Deductible	Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount not subject to Deductible	80% of Allowed Amount not subject to Deductible
Physician's Visits	$25 Copay per visit 100% of Allowed Amount not subject to Deductible	$25 Copay per visit 70% of Allowed Amount not subject to Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Early Intervention Services	$20 Copay per visit Allowed Amount not subject to Deductible	$20 Copay per visit 80% of Allowed Amount not subject to Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$100 Copay per visit 100% of Allowed Amount not subject to Deductible	$100 Copay per visit 100% of Allowed Amount not subject to Deductible
Diagnostic X-ray Services	Allowed Amount not subject to Deductible	Allowed Amount not subject to Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount not subject to Deductible	Allowed Amount not subject to Deductible
Tests & Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Injections	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information. For insulin drugs the total amount of Deductible, Copayments or Coinsurance shall not exceed $50 for an individual prescription of up to a 30-day supply. Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy for insulin drugs the total amount of Deductible, Copayments or Coinsurance shall not exceed $150 for an individual prescription of up to a 90-day supply.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $15 Copay per prescription Tier 1 $60 Copay per prescription Tier 2 25% Coinsurance per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured will pay the same as the retail Copay and/or Coinsurance (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	No Benefits

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Durable Medical Equipment	80% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Consultant Physician Fees	$25 Copay per visit 100% of Allowed Amount not subject to Deductible	$25 Copay per visit 70% of Allowed Amount not subject to Deductible
Dental Treatment	Paid as any other Injury or Sickness	Paid as any other Injury or Sickness
Mental Illness Treatment See also Benefits for Mental Illness and Substance Use Disorder.	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount not subject to Deductible	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 70% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount not subject to Deductible
Substance Use Disorder Treatment See also Benefits for Mental Illness and Substance Use Disorder.	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount not subject to Deductible	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 70% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount not subject to Deductible
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	No Benefits	No Benefits
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See also Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Home Health Care 100 visits maximum per Policy Year Limits do not apply to services provided for infusion therapy, home dialysis, Mental Illness or Substance Use Disorders. Private Duty Nursing services limited to 16 hour per Policy Year.	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospice Care See Benefits for Hospice Care	Paid as any other Sickness	Paid as any other Sickness
Inpatient Rehabilitation Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Skilled Nursing Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Urgent Care Center	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	$20 Copay per visit 70% of Allowed Amount not subject to Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
Approved Clinical Trials See also Benefits for Clinical Trials for Treatment Studies on Cancer	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Allergy Testing/Treatment	Paid as any other Sickness	Paid as any other Sickness
Dialysis	Paid as any other Sickness	Paid as any other Sickness
Genetic Testing	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids Limited to one Hearing Aid per hearing impaired ear every 24 months, up to $1,500 per Hearing Aid for an Insured age 18 or younger.	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount not subject to Deductible
Infertility	Paid as any other Sickness	Paid as any other Sickness
Infusion Therapy	Paid as any other Sickness	Paid as any other Sickness
Lymphedema	Paid as any other Sickness	Paid as any other Sickness
Medical Foods See also Benefits for Formula and Enteral Nutrition Products.	Allowed Amount after Deductible	Allowed Amount after Deductible
Medical Supplies Limited to a 31-day supply per purchase.	Allowed Amount after Deductible	Allowed Amount after Deductible
Oral and Maxillofacial Surgery	Paid as any other Sickness	Paid as any other Sickness
Ostomy Supplies	Allowed Amount after Deductible	Allowed Amount after Deductible
Reconstructive Procedures	Paid as any other Sickness	Paid as any other Sickness
Prosthetic Devices	80% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Sleep Disorders	Paid as any other Sickness	Paid as any other Sickness
Sterilization	Paid as any other Sickness	Paid as any other Sickness
TMJ Disorders	Paid as any other Sickness	Paid as any other Sickness
Vision Correction	Allowed Amount after Deductible	Allowed Amount after Deductible
Wigs	Allowed Amount after Deductible	Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Routine Adult Vision Benefits are limited to one routine eye examination and one pair of eyeglasses per Policy Year. **This benefit is separate from and does not apply to Pediatric Vision Services.**	Allowed Amount after Deductible	Allowed Amount after Deductible
Adult Dental Examination Benefits are limited to one dental examination per Policy Year. **This benefit is separate from and does not apply to Pediatric Dental Services.**	80% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible

UNITEDHEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

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

President

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

Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

Network Benefits - these benefits apply when the Insured Person chooses to obtain Covered Dental Services from a Network Dental Provider. Insured Persons generally are required to pay less to the Network Dental Provider than they would pay for services from an out-of-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will the Insured Person be required to pay a Network Dental Provider an amount for a Covered Dental Service that is greater than the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, the Insured Person must obtain all Covered Dental Services directly from or through a Network Dental Provider.

Insured Persons must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. The Insured Person can check the participation status by calling the Company and/or the provider. The Company can help in referring the Insured Person to Network Dental Providers.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call the Company at the number stated on their identification (ID) card to determine which providers participate in the Network.

Out-of-Network Benefits - these benefits apply when the Insured Person decides to obtain Covered Dental Services from out-of-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. Insured Persons may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. When the Insured Person obtains Covered Dental Services from out-of-Network Dental Providers, the Insured Person must file a claim with the Company to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

The Insured Person is eligible for benefits for Covered Dental Services listed in this endorsement if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this endorsement.

What Is a Pre-Treatment Estimate?

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

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

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

Does Pre-Authorization Apply?

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

Section 2: Benefits for Pediatric Dental Services

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

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

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

Network Benefits:

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

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

Out-of-Network Benefits:

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

Dental Services Deductible

Benefits for pediatric Dental Services provided under this endorsement are not subject to the Policy Deductible stated in the Policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible.

For any combination of Network and Out-of-Network Benefits, the Dental Services Deductible per Policy Year is $500 per Insured Person.

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

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefit Description

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
Diagnostic Services - (Subject to payment of the Dental Services Deductible.)		
Evaluations (Checkup Exams) Limited to one time per six months. Covered as a separate benefit only if no other service was done during the visit other than X-rays. Routine oral evaluations begin with the eruption of the first tooth. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient D0160 - Detailed and extensive oral evaluation - problem focused, by report	50%	50%
Intraoral Radiographs (X-ray) Limited to one series of films per 36 months. D0210 - Intraoral comprehensive series of radiographic images D0709 - Intraoral - comprehensive series of radiographic images - image capture only D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only		
The following services are limited to two per 12 months. D0220 - Intraoral - periapical first radiographic image D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal radiographic image D0374 - Intraoral tomosynthesis - periapical radiographic image D0389 - Intraoral tomosynthesis - periapical radiographic image - image capture only D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only	50%	50%
The following services are not subject to a frequency limit. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0273 - Bitewings - three radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only D0708 - Intraoral - bitewing radiographic image - image capture only```````````````````	50%	50%
Limited to one time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only D0702 - 2-D Cephalometric radiographic image - image capture only	50%	50%
The following service is limited to two images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0470 - Diagnostic casts D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	50%	50%
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to one time every six months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	50%	50%
Fluoride Treatments The following services are limited to one time every six months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride - excluding varnish	50%	50%
Sealants (Protective Coating) The following services are limited to once per first or second permanent molar per lifetime. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	50%	50%
Space Maintainers (Spacers) The following services are limited to one per quadrant every 24 months. D1510 - Space maintainer - fixed - unilateral - per quadrant D1516 - Space maintainer - fixed - bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant		
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces (anterior) D2989 - Excavation of a tooth resulting in the determination of non-restorability	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
The following services are subject to a limit of one time every 60 months. Includes veneers (codes D2960, D2961 and D2962). D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D2544 - Onlay - metallic - four or more surfaces D2740 - Crown - porcelain/ceramic D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following services are limited to one time per tooth every 60 months. D2929 - Prefabricated porcelain/ceramic crown - primary tooth D2950 - Core buildup, including any pins when required D2951 - Pin retention - per tooth, in addition to restoration	50%	50%
The following services are limited to 1 one time per tooth every 60 months. D2954 - Prefabricated post and core in addition to crown D2970 - Temporary crown (fractured tooth)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure	50%	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a The following services are not subject to a frequency limit. D3110 - Pulp cap – direct (excluding final restoration) D3120 - Pulp cap – indirect (excluding final restoration) D3220 - Therapeutic pulpotomy (excluding final restoration) D3221 - Pulpal debridement, primary and permanent teeth D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit.	50%	50%
	50%	50%
D3110 - Pulp cap – direct (excluding final restoration)	50%	50%
D3120 - Pulp cap – indirect (excluding final restoration)	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one time per quadrant every 24 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following services are limited to one every 36 months. D4240 - Gingival flap procedure, including root planing - four or more	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
contiguous teeth or tooth bounded spaces per quadrant D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant D4249 - Clinical crown lengthening - hard tissue		
The following services are limited to one time per quadrant every 60 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4286 - Removal of non-resorbable barrier	50%	50%
The following service is not subject to a frequency limit. D4263 - Bone replacement graft retained natural tooth - first site in quadrant D4270 - Pedicle soft tissue graft procedure	50%	50%
The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure each additional contiguous tooth D4320 - Provision splinting - intracoronal D4321 - Provision splinting – extracoronal D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns	50%	50%
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation		
The following service is limited to a frequency of one time every 12 months. D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50%	50%
The following service is limited to one time every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture (each tooth) D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth D5640 - Replace broken teeth - per tooth	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture		
The following services are limited to rebasing performed more than six months after the initial insertion with a frequency limitation of one time per 24 months. D5710 - Rebase complete maxillary denture D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) - D5876 - Add metal substructure to acrylic full denture (per arch)	50%	50%
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
The following service is not subject to a frequency limit. D5951 - Maxillofacial prosthetics (feeding aid)	50%	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic		
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are limited to one time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal	50%	50%
The following services are not subject to a frequency limit. D6930 - Re-cement or re-bond FPD D6980 - FPD repair necessitated by restorative material failure	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap , if indicated D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal, impacted teeth only	50%	50%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth D7285 - Biopsy of oral tissue (hard) D7286 - Biopsy of oral tissue (soft) D7288 - Brush biopsy - transepithelial sample collection	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following services are not subject to a frequency limit. D7450 - Removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm D7451 - Removal of odontogenic cyst or tumor - lesion greater than 1.25cm D7471 - Removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst D7510 - Incision and drainage of abscess, intraoral soft tissue D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7971 - Excision of pericoronal gingiva	50%	50%
The following services are limited to one every 36 months. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	50%	50%
The following services are limited to one per lifetime. D7960 - Frenulectomy D7963 - Frenuloplasty	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative treatment of dental pain - per visit	50%	50%
Covered only when clinically Necessary. D9210 – local anesthesia not in conjunction with operative or surgical procedures. D9220 – Deep sedation/general anesthesia first 30 minutes.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D9221 – Dental sedation/general anesthesia – first 15 minutes. D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9610 - Therapeutic parenteral drug single administration		
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	50%	50%
The following services are limited to one guard every 12 months. D7880 - Occlusal orthotic device for TMJ D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement: transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain/ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6080 - Implant maintenance procedure D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6088 - Implant supported crown - titanium and titanium alloys D6089 - Accessing and retorquing loose implant screw per screw D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6095 - Repair implant abutment, by report D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of implant replacement D6105 - Removal of implant body not requiring bone removal nor flap elevation D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys D6197 - Replacement of restorative material used to close an access opening of a screw retained implant supported prothesis, per implant		
The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant D6107 - Guided tissue regeneration - non-resorbable barrier, per implant	50%	50%
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement: transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain/ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6080 - Implant maintenance procedure D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6089 - Accessing and retorquing loose implant screw per screw D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6095 - Repair implant abutment, by report D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of implant replacement D6105 - Removal of implant body not requiring bone removal nor flap elevation D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys D6197 - Replacement of restorative material used to close an access opening of a screw retained implant supported prothesis, per implant The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant D6107 - Guided tissue regeneration - non-resorbable barrier, per implant		
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for severe, dysfunctional, handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy (including appliances for thumb sucking and tongue thrusting) D8220 - Fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting) D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8692 - Replacement of lost or broken retainer D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular	50%	50%

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this endorsement in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. This exclusion does not apply to an occlusal orthotic device for TMJ, which is covered only for temporomandibular pain dysfunction or associated musculature.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this endorsement to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person’s family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

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

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

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

Section 5: Defined Terms for Pediatric Dental Services

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

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

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

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

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

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

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

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

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

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

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

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

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)
The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this endorsement. The definition of Necessary used in this endorsement relates only to benefits under this endorsement and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

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

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

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

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

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

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

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

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

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

Out-of-Network Benefits:
Benefits for Vision Care Services from out-of-Network Vision Care Providers are determined as a percentage of the provider's billed charge.

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

Policy Deductible
Benefits for pediatric Vision Care Services provided under this endorsement are not subject to any Policy Deductible stated in the Policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for Vision Care Services under this endorsement does not apply to the Policy Deductible stated in the Policy Schedule of Benefits.

What Are the Benefit Descriptions?

Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copayments and Coinsurance stated under each Vision Care Service in the Schedule of Benefits below.

Routine Vision Examination

A routine vision examination of the eyes and according to the standards of care in the area where the Insured Person resides, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) – helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation – how well the Insured Person sees up close (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

Eyeglass Lenses

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

Covered Services also include a choice of eyeglass lenses, including polycarbonate and photochromic lenses. Benefits include factory scratch coating and UV coating.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

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

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

Eyeglass Frames

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

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

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

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

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

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company.

Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus when the Insured Person's vision is not correctable to 20/40 in either or both eyes using standard eyeglass lenses.
- High ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- When the Insured Person's vision can be corrected three lines of improvement on the visual acuity chart when compared to the best corrected standard eyeglass lenses.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Schedule of Benefits

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
• Single Vision		100% after a Copayment of $40.	50% of the billed charge.
• Bifocal		100% after a Copayment of $40.	50% of the billed charge.
• Trifocal		100% after a Copayment of $40.	50% of the billed charge.
• Lenticular		100% after a Copayment of $40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Photochromic lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.
• UV coating		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - $160.		100% after a Copayment of $15.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - $200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - $250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company. Information about claim timelines and responsibilities in the General Provisions section in the Certificate of Coverage applies to Vision Care Services provided under this endorsement, except that when the Insured Person submits a Vision Services claim, the Insured Person must provide the Company with all of the information identified below.

Reimbursement for Vision Care Services

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

- Insured Person’s itemized receipts.
- Insured Person's name.
- Insured Person's identification number from the ID card.
- Insured Person's date of birth.

Submit the above information to the Company:

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

By facsimile (fax):
248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

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

UnitedHealthcare Vision Network - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the Policy.

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

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

UNITEDHEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

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

President

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

UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

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

The Insured must either show their ID card to the Network Pharmacy when the prescription is filled or provide the Network Pharmacy with identifying information that can be verified by the Company during regular business hours. If the Insured does not show their ID card to the Network Pharmacy or provide verifiable information, they will need to pay for the Prescription Drug at the pharmacy.

The Insured may then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting www.uhcsr.com/wm and logging in to their online account or by calling *Customer Service* at 1-855-828-7716.

Information on Network Pharmacies is available at www.uhcsr.com/wm or by calling *Customer Service* at 1-855-828-7716.

If the Insured does not use a Network Pharmacy, no benefits are available and the Insured will be responsible for paying the full cost for the Prescription Drug unless the non-Network pharmacy enters into an agreement with the Company as noted below.

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

Copayment and/or Coinsurance Amount

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

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

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

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

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

How Do Supply Limits Apply?

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

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

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject, from time to time, to the Company's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

The Insured may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Company at www.uhcsr.com/wm or by calling *Customer Service* at 1-855-828-7716.

Refill Synchronization

Prescription Drug Products dispensed by a Network Pharmacy for a partial supply of a covered prescription drug, in order to synchronize your medications, will be covered at a prorated cost-sharing rate.

What Happens When 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. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular reference product.

Designated Pharmacies

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

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Pharmacy, the Insured may opt-out of the Designated Pharmacy program at www.uhcsr.com/wm or by calling *Customer Service* at 1-855-828-7716.

If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, the Insured will be responsible for the entire cost of the Prescription Drug Product.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, benefits will be paid based on the out-of-Network Benefit for that Prescription Drug Product.

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

Do Prior Authorization Requirements Apply?

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

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

If the Insured does not obtain prior authorization from the Company before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to the Company's review and change. There may be certain Prescription Drug Products that

require the Insured to notify the Company directly rather than the Insured's Physician or pharmacist. The Insured may determine whether a particular Prescription Drug requires prior authorization at www.uhcsr.com/wm or by calling *Customer Service* at 1-855-828-7716.

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

When the Insured submits a claim on this basis, the Insured may pay more because they did not obtain prior authorization from the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Copayment and/or Coinsurance and any Deductible that applies.

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

Does Step Therapy Apply?

Certain Prescription Drug Products for which benefits are provided are subject to step therapy requirements. In order to receive benefits for such Prescription Drug Products an Insured must use a different Prescription Drug Product(s) first. However, the Insured or the Insured's representative may request an exception request and a determination will be provided no later than 72 hours after receipt of the request. An expedited exception request will be reviewed and a determination will be provided no later than 24 hours after receipt of the request.

A step therapy exception request shall be granted if the prescribing provider's submitted justification and supporting clinical documentation, if needed, are determined to support the prescribing provider's statement that:

1. The required prescription drug is contraindicated;
2. The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
3. The patient has tried the step therapy-required prescription drug while under their current or a previous health benefit plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
4. The patient is currently receiving a positive therapeutic outcome on a prescription drug recommended by his provider for the medical condition under consideration while on a current or the immediately preceding health benefit plan.

The Insured may find out whether a Prescription Drug Product is subject to step therapy requirements at www.uhcsr.com/wm or by calling *Customer Service* at 1-855-828-7716.

When Does the Company Limit Selection of Pharmacies?

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

Coverage Policies and Guidelines

The UnitedHealthcare Pharmacy & Therapeutics Committee ("P & T Committee") serves as an advisory body to UHCP by providing consultation for the clinical evaluation of drugs for placement on the Prescription Drug List, and clinical programs associated with drug management. As necessary, the P & T Committee will review and evaluate clinical coverage guidelines for Prescription Drug Products covered under the pharmacy benefit including criteria, standards, and educational intervention methods.

The Company's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Company's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug

Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others, therefore; a Prescription Drug may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

The Company may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to the Policyholder, except if the change amounts to a benefit reduction, the Company will provide the Policyholder with written notice of a benefit reduction sixty (60) days before it becomes effective. The Insured Person will be notified of the change thirty (30) days prior to the effective date of the benefit reduction.

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

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

Rebates and Other Payments

We will apply any coupons, discounts, product vouchers, or any other reduction received from manufacturers or other third parties for Prescription drugs toward the Insured Person's Deductible, Copayments, or cost-sharing responsibility, or Out-of-Pocket Maximum associated with this Policy.

The Company may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that the Insured may purchase prior to meeting any applicable Deductible. The Company will pass these rebates on to the Insured Person and they will be applied or and taken into account in determining the Insured's Copayment and/or Coinsurance.

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

Definitions

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician will be classified as Brand-name by the Company.

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

Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are a Designated Pharmacy.

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician will be classified as a Generic by the Company.

Maintenance Medication means a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. The Insured may find out if a Prescription Drug Product is a Maintenance Medication at www.uhcsr.com/wm or by calling *Customer Service* at 1-855-828-7716.

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

New Prescription Drug Product means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) until the earlier of the following dates:
- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

New Prescription Drug Products will be assigned to the highest applicable tier on your Prescription Drug List until it is placed in a tier by our PDL Management Committee. There are certain circumstances where a New Prescription Drug Product may be assigned to a lower tier upon approval by the FDA (e.g., a generic may be placed on the same tier or a lower tier than the brand).

Out-of-Network Reimbursement Rate means the amount the Company will pay to reimburse an Insured for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

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

PPACA means Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications means the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, or Deductible) as required by applicable law under any of the following:
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Insured may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives at www.uhcsr.com/wm *or* by calling *Customer Service* at 1-855-828-7716.

Preferred 90 Day Retail Network Pharmacy means a retail pharmacy that the Company identifies as a preferred pharmacy within the network for Maintenance Medication.

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

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

Prescription Drug List means a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's review and change from time to time. The Insured may find out which tier a particular Prescription Drug Product has been placed at www.uhcsr.com/wm or call *Customer Service* at 1-855-828-7716.

Prescription Drug List (PDL) Management Committee means the committee that the Company designates for placing Prescription Drugs into specific tiers.

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

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

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

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

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

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

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

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

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for a Medical Emergency.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
5. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law. This exclusion does not apply to Medicaid.
7. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
9. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
10. Certain unit dose packaging or repackagers of Prescription Drug Products.
11. Medications used for cosmetic or convenience purposes.
12. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3 .)
13. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
14. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
15. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
16. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
17. A Prescription Drug Product with either:
    - An approved biosimilar.

- A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

18. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
19. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.]
20. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
21. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
22. Diagnostic kits and products, including associated services.
23. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
24. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
25. A Prescription Drug Product that contains marijuana, including medical marijuana.

Right to Request an Exclusion Exception

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

Please note, if the request for an exception is approved, the Insured may be responsible for paying the applicable Copayment and/or Coinsurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the Schedule of Benefits.

Urgent Requests

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

External Review

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

Expedited External Review

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

BALANCE BILLING PROTECTION FOR OUT-OF-NETWORK SERVICES

Starting January 1, 2021, Virginia state law may protect you from "balance billing" when you get:

- ***EMERGENCY SERVICES*** from an out-of-network hospital, or an out-of-network doctor or other medical provider at a hospital; or
- ***NON-EMERGENCY SURGICAL OR ANCILLARY SERVICES*** from an out-of-network lab or health care professional at an in-network hospital, ambulatory surgical center or other health care facility.

What is balance billing?

- An **"IN-NETWORK"** health care provider has signed a contract with your health insurance plan. Providers who haven't signed a contract with your health plan are called **"OUT-OF-NETWORK"** providers.
- In-network providers have agreed to accept the amounts paid by your health plan after you, the patient, has paid for all required cost sharing (copayments, coinsurance and deductibles for covered services).
- But, if you get all or part of your care from out-of-network providers, you could be billed for the difference between what your plan pays to the provider and the amount the provider bills you. This is called "balance billing."
- The new Virginia law prevents certain balance billing, ***but it does not apply to all health plans.***

Applies	May Apply	Does Not Apply
○ Fully insured managed care plans, including those bought through HealthCare.gov ○ The state employee health plan ○ Group health plans that opt-in	○ Employer-based coverage ○ Health plans issued to an employer outside Virginia ○ Short-term limited duration plans	○ Health plans issued to an association outside Virginia ○ Health plans that do not use a network of providers ○ Limited benefit plans

How can I find out if I am protected?

Be sure to check your plan documents or contact your health plan to find out if you are protected by this law. When you schedule a medical service, ask your health care provider if they are in-network. Insurers are required to tell you (on their websites or on request) which providers are in their networks. Hospitals and other health care providers also must tell you (on their websites or on request) which insurance plans they contract with as in-network providers. Whenever possible, you should use in-network providers for your health care to avoid paying more.

After you receive medical services, your health plan will send you an "Explanation of Benefits" (EOB) that will tell you what you must pay the provider. Save the EOB and check that any bills you receive are not more than the amount listed.

When you *cannot* be balance billed:

If the new law applies to your health plan, an out-of-network provider can no longer balance bill or collect more than your plan's in-network cost-sharing amounts for either (1) emergency care or (2) when you receive lab or professional services (like surgery, anesthesiology, pathology, radiology, and hospitalist services) at an in-network facility.

What should I know about these situations?

Your cost-sharing amount will be based on what your plan usually pays an in-network provider in your area. These payments must count toward your in-network deductible and out-of-pocket limit. If the out-of-network provider collects more than this from you, the provider must refund the excess with interest.

Exception: If you have a high deductible health plan with a Health Savings Account (HSA) or a catastrophic health plan, you must pay any additional amounts your plan is required to pay to the provider, up to the amount of your deductible.

What if I am billed too much?

If you are billed an amount more than your payment responsibility shown on your EOB, or you believe you've been wrongly billed, you can file a complaint with the State Corporation Commission's (SCC) Bureau of Insurance.

To contact the SCC for questions about this notice visit: scc.virginia.gov or call: 1-877-310-6560.

NON-DISCRIMINATION NOTICE

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

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

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

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

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

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

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

Complaint forms are available at: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

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

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

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

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይሻኖሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee
ᎦᎾᏂᎬᏍᏗ ᎤᎾᏓᏍᏗᏓᏁᏗ ᎤᎾᏓᎵᏊET ᏂᎯ RGᎧᏁᎢᏍᏗᏓᏁᏗᏱᏊT ᏂᏓEGGᎧᎾ D4ᏫT. ᎭᏩ DᏂ ᏫᏏWᎧᏤ 1-866-260-2723.

Chinese
您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo
Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole
Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German
Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

Hawaiian
Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong
Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo
Enyemaka na-ahazi asụsụ, bu n'efu, dịrị gị. Kpọọ 1-866-260-2723.

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian
Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。 1-866-260-2723 までお電話ください。

Karen
ကျိုတ်မၤစၢၤအဂီၤနမၤန့ၢ်ဆီၤသ့ဝဲလၢတလိာ်ဟ့ဉ်အပူၤဘာ်(ဧီလီ)နှဉ်လီၤ, ဝံသးစူၤလဲးကျိုးဘာ်1-866-260-2723တက့ၢ်.

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani
خزمەتگوزاری یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

Laotian
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ເຈົ້າທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi
भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeḷọk wōṇāān. Jouj im kalḷọk 1-866-260-2723.

Micronesian- Pohnpeian
Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo
Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shǫǫdí kohjį' 1-866-260-2723 hodíilnih.

Nepali
भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka
Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn col 1-866-260-2723.

Norwegian
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

Polish
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa
O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde
E woodi walliinde dow wolde caahu ngam maada. Noodu 1-866-260-2723.

Swahili
Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
ܚܕܡܬ ܥܕܪܬ ܠܫܢ̈ܐ ܡܬܬܠ̈ܡ ܠܟ ܒܠܝܢ ܒܚܢܡ ܕܠ ܡܬܚܠܒ ܠܟ ܒܫܘܠܡܐ ܘܒܫܘܠ̈ܡ ܐܢ ܐܬܪ ܠܟ ܠܡܬܨܠ ܒ 1-866-260-2723.

Tagalog
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข
1-866-260-2733

Tongan- Fakatonga
‘Oku ‘i ai pē ‘a e sēvesi ki he lea‘ ke tokoni kiate koe pea ‘oku ‘atā ia ma’au ‘o ‘ikai ha totongi. Kātaki ‘o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

Ukrainian
Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 1-866-260-2723 پر کال کریں۔

Vietnamese
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddish
שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba
Isẹ́ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ́. Pe 1-866-260-2723.