

UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of

CCCS-MN-Gold Enhanced 1

2024-2025

This Certificate of Coverage is Part of Policy # 2024-203096-61

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.

The logo for United Healthcare, featuring the words "United" and "Healthcare" stacked vertically in a blue, serif font. A registered trademark symbol (®) is located at the end of "Healthcare".

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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 located on the Insured's ID card. 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 eligible students and participants registered at an accredited institution of higher learning are automatically enrolled unless proof of comparable coverage is furnished. Specific eligibility requirements are set forth in each Institution of Higher Education's insurance plan materials.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse and dependent children under 26 years of age.

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.
 - 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.

Section 2: Effective and Termination Dates

The Master Policy on file with the consortium sponsor CCCS becomes effective at 12:01 a.m., July 1, 2024. 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., September 30, 2025. 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.

There is no pro-rata or reduced premium payment for late enrollees. A student who requests to cancel coverage under the Policy will receive a refund of unearned premium as of the time of cancellation if the unearned premium is for a period of more than one month. The return of unearned premium will be delivered to the Insured within 30 days following receipt of the Insured's request for cancellation.

Coverage shall continue in force during the Grace Period unless: 1) the Insured has given the Company written notice of discontinuance; or 2) not less than five days prior to the premium due date, the Company has delivered to the Insured or has mailed to the Insured's last address as shown by the records of the Company, written notice of its intention not to renew this Policy beyond the period for which the premium has been accepted.

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

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 12 months after the Termination Date.

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

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

Section 4: 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.

The easiest way to locate Preferred Providers is through the plan's website at www.uhcsr.com. 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 the number on their Insured's ID card 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 the number on their ID card and/or by asking the provider when making an appointment for services. A directory of providers is available on the plan's website at www.uhcsr.com.

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 the number on their ID card Insured's ID card to find out if they are eligible for continuity of care benefits.

"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 Ancillary Services received at certain 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-Ancillary Services received at certain 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-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.

For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social*

Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary.

Consumer Protections Against Balance Billing

Out-of-Network Provider Balance Billing Prohibition

Balance billing is prohibited when an Insured receives services from:

- An Out-of-Network Provider at a Preferred Provider Hospital or ambulatory surgical center, as described by the No Surprises Act, including any federal regulations under that act.
- A Preferred Provider that sends a specimen taken from the Insured in the Preferred Provider's practice setting to an Out-of-Network laboratory, pathologist, or other medical testing facility.
- An Out-of-Network Provider or facility providing Emergency Services, and other services as described in the requirements of the No Surprises Act.

The services described above are not prohibited from balance billing if the Insured gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the Policy. The informed consent must comply with all requirements of the No Surprises Act, including any federal regulations adopted under the act.

Cost-Sharing and Independent Dispute Resolution

If the Insured receives services as noted above:

- The Insured's financial responsibility for the Out-of-Network Provider services shall be the same cost-sharing requirements, including Copayments, Deductibles, Coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the Insured from a Preferred Provider and shall be applied to the Insured's Preferred Provider Out-of-Pocket Maximum.
- The Company will attempt to negotiate reimbursement, less any applicable cost-sharing, for the Out-of-Network Provider services with the Out-of-Network Provider. If the attempt to negotiate reimbursement for the Out-of-Network Provider services do not result in a resolution, either party may initiate the federal independent dispute resolution process pursuant to the No Surprises Act, including any federal regulations adopted under the act.

Estimated Reimbursement Request

If an Insured intends to receive specific health care services from a Preferred Provider, the Insured or their designee may request a good faith estimate of the Covered Medical Expense amount for that service by calling the Customer Service Department at located on the Insured's ID card. The Company will provide the Insured with a good faith estimate which will include an estimate of the Insured's Out-Of-Pocket Maximum. This estimate will be provided within ten business days from the date the Company receives a complete request.

A good faith estimate is not legally binding, or is it a guarantee of final costs for services, a final determination of benefits eligibility or Preferred Provider participation.

Minnesota Patient Protection Act

If a Health Care Provider or Health Plan determines or receives notice from an Insured that a bill from the Health Care Provider to the Insured may contain Billing Errors, the Health Care Provider or Health Plan must notify the Insured:

1. Of the potential Billing Error.
2. That the Health Care Provider or Health Plan must review the bill and correct any Billing Errors found.
3. That while the review is being conducted, the Health Care Provider must not bill the Insured for any health treatment or service subject to review for potential Billing Errors.

This notice must be transmitted to the Insured within 30 days after the date the Health Care Provider or Health Plan company determines or receives notice that the patient's bill may contain one or more billing errors.

When a Health Care Provider or Health Plan company completes a review of a bill for potential Billing Errors, the Health Care Provider or Health Plan company must:

1. Notify the Insured that the review is complete.
2. Explain in detail how any identified Billing Errors were corrected or explain in detail why the Health Care Provider or Health Plan company did not modify the bill as requested by the Insured.
3. Include applicable coding guidelines, references to health records, and other relevant information.

This notice must be transmitted to the Insured within 30 days after the date the Health Care Provider or Health Plan company completes the review.

For the purposes of the Minnesota Patient Protection Act, the following terms are defined as:

"Billing error" means an error in a bill from a health care provider to a patient for health treatment or services that affects the amount owed by the patient according to that bill. Billing error includes but is not limited to: (1) miscoding a health treatment or service; (2) an error in determining whether a health treatment or service is covered under the Insured's Health Plan; or (3) an error in determining the cost-sharing owed by the Insured.

"Health care provider" means:

1. A health professional who is licensed or registered by the state to provide health treatment and services within the professional's scope of practice and in accordance with state law.
2. A group practice.
3. A hospital.

"Health plan" has the meaning given in section 62A.011, subdivision 3.

"Hospital" means a health care facility licensed as a hospital under sections 144.50 to 144.56.

State Continuity of Care

If an Insured is currently receiving treatment for the conditions listed below, and the Insured's plan changes, The Insured may request to receive Covered Medical Expenses under the terms of this Policy when the services are provided by the Insured's current Physician, subject to the following:

1. Benefits will be provided for up to 120 days if the Insured is engaged in a current course of treatment for one or more of the following conditions:
 - An acute condition.
 - A life-threatening mental or physical Sickness.
 - Pregnancy.
 - A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death.
 - A disabling or chronic condition that is in an acute phase.
2. Benefits will be provided for the remainder of the Insured's life if a Physician certifies that the Insured has an expected lifetime of 180 days or less.

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 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.
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.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. **Routine Newborn Care.**

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

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

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

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

If the mother is discharged earlier than the minimum time frames shown above, benefits will be provided for one home visit by a Registered Nurse. The home visit must be conducted within four days following the mother and child's early discharge. Services provided during the home visit include, but are not limited to:

- Parent education.
- Assistance and training in breast and bottle feeding.
- Any necessary and appropriate clinical tests.

5. **Surgery.**

Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**

Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**

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

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

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

9. **Physician's Visits.**

Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**

Benefits are limited to routine tests such as:

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

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

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

Outpatient

11. **Surgery.**
Physician's fees for outpatient surgery.
12. **Day Surgery Miscellaneous.**
Facility charge and the charge for services and supplies in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.
13. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with outpatient surgery.
14. **Anesthetist Services.**
Professional services administered in connection with outpatient surgery.
15. **Physician's Visits.**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Physician's Visits Benefits do not apply when related to surgery or Physiotherapy. Benefits for surgery are paid under the Surgery Benefits. Benefits for Physiotherapy are paid under the Physiotherapy Benefits.

Physician's Visits for preventive care are provided as specified under Preventive Care Services.
16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
 - Physical therapy.
 - Occupational therapy.
 - Cardiac rehabilitation therapy.
 - Manipulative treatment.
 - Speech therapy.
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.
17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
 - Facility charge for use of the emergency room and supplies.
All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. **Diagnostic X-ray Services.**
Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
19. **Radiation Therapy.**
See Schedule of Benefits.
20. **Laboratory Procedures.**
Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
21. **Tests and Procedures.**
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
 - Physician's Visits.
 - Physiotherapy.
 - X-rays.
 - Laboratory Procedures.

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

- Inhalation therapy.
- Intravenous infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis, hemodialysis, and peritoneal dialysis.

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

22. **Injections.**

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

23. **Chemotherapy.**

See Schedule of Benefits.

24. **Prescription Drugs.**

See Schedule of Benefits.

Other

25. **Ambulance Services.**

See Schedule of Benefits.

26. **Durable Medical Equipment.**

Durable Medical Equipment must be all of the following:

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

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

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

See also Benefits for Orthotic and Prosthetic Devices.

See also Benefits for Intermittent Catheters.

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

The Insured may call the Customer Service Department at located on the Insured's ID card with any questions about coverage for Durable Medical Equipment.

27. **Consultant Physician Fees.**

Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**

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

- Injury to Sound, Natural Teeth.
- Outpatient services to treat an underlying condition, such as removal of teeth to complete radiation for cancer of the jaw, cysts, or lesions.

Benefits also include Medically Necessary hospitalization and anesthesia for dental care, limited to services provided for:

- An Insured who: a) is under age five; or b) is severely disabled; or c) has a medical condition and requires hospitalization or general anesthesia for dental care.
- An Insured between the ages of five and 12 if: a) care in a dental office has been unsuccessful and the usual methods of behavior modification have not been successful; or b) extensive amounts of restorative care, exceeding four appointments, is required.

Benefits also include Medically Necessary services for treatment of medical complications related to non-covered dental services, including complications of the head, neck, or substructures.

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

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

29. **Mental Illness Treatment.**

Benefits will be paid for services received:

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

30. **Substance Use Disorder Treatment.**

See Benefits for Alcoholism, Chemical Dependency and Drug Addiction.

31. **Maternity.**

Same as any other Sickness for maternity-related services, including prenatal and postnatal care.

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.

If the mother is discharged earlier than the minimum time frames shown above, benefits will be provided for one home visit by a Registered Nurse. The home visit must be conducted within four days following the mother and child's early discharge. Services provided during the home visit include, but are not limited to:

- Parent education.
- Assistance and training in breast and bottle feeding.
- Any necessary and appropriate clinical tests.

See also Benefits for Maternity Medical Facility Transfer.

32. **Complications of Pregnancy.**

Same as any other Sickness.

33. **Preventive Care Services.**

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*, including the U.S. Food and Drug Administration (FDA) approved female contraceptive methods, as well as the clinical services, including patient education and counseling, needed for the provision of the contraceptive method.

34. **Reconstructive Breast Surgery Following Mastectomy.**

Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Reconstructive Surgery.

35. **Diabetes Services.**

Same as any other Sickness for all Physician Prescribed Medically necessary equipment and supplies used in connection with the management and treatment of gestational, type I or type II 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.
- Medical eye exams (dilated retinal exams).
- Preventive foot care for diabetes.
- Prescription Drugs, equipment, and supplies based on the Insured's specific medical needs, including, but not limited to:
 - Insulin pumps and supplies.
 - 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.

36. **Home Health Care.**

Services received from a licensed home health agency that are:

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

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

37. **Hospice Care.**

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

Hospice care includes:

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

38. **Inpatient Rehabilitation Facility.**

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

39. **Skilled Nursing Facility.**

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

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

40. **Urgent Care Center.**

Benefits are limited to:

- Facility or clinic fee billed by the Urgent Care Center.

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

41. **Hospital Outpatient Facility or Clinic.**

Benefits are limited to:

- Facility or clinic fee billed by the Hospital.

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

42. **Approved Clinical Trials.**

Routine Patient 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 costs" means all items and services covered by the Policy when the items or services are typically covered for an Insured who is not a qualified individual enrolled in an approved clinical trial. Routine patient costs do not include:

- An investigational item, device or service that is part of the trial.
- An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is 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 the individual's diagnosis.
- An item or service customarily provided and paid for by the sponsor of a 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. 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.

43. **Transplantation Services.**

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

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

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

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

44. **Pediatric Dental and Vision Services.**

Benefits are payable as specified in the Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits sections.

45. **Genetic Testing.**

Benefits are limited to genetic testing following genetic counseling when ordered by a Physician and:

- Which is determined to be Medically Necessary.
- The results would influence the treatment or management of a condition or family planning decision.

This Policy does not use the results of genetic tests to determine eligibility for coverage, establish premium, limit the availability of coverage, renew coverage or in underwriting decisions.

46. **Medical Foods.**

Benefits are limited to the following:

- Enteral feedings that are the sole source of nutrition to treat a life-threatening condition.
- Oral amino based elemental formula.
- Amino acid-based elemental formula which is Medically Necessary to treat:
 - Cystic fibrosis.
 - Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders.
 - IgE mediated allergies to food proteins.
 - Food protein-induced enterocolitis syndrome.
 - Eosinophilic esophagitis.
 - Eosinophilic gastroenteritis.
 - Eosinophilic colitis.
 - Mast cell activation syndrome.

Medical foods must be prescribed by a Physician. The written prescription must accompany the claim when submitted. See also Benefits for Phenylketonuria Treatment.

Section 7: Mandated Benefits

BENEFITS FOR ALCOHOLISM, CHEMICAL DEPENDENCY AND DRUG ADDICTION

Benefits will be paid for the treatment of alcoholism, chemical dependency or drug addiction as specified in the Policy Schedule of Benefits for Substance Use Disorder Treatment to any Minnesota resident entitled to coverage hereunder when treatment is rendered in:

1. A licensed Hospital.
2. A residential treatment program as licensed by the state of Minnesota pursuant to diagnosis or recommendation by a Physician.
3. A non-residential treatment program approved or licensed by the state of Minnesota.

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

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER

Benefits will be paid the same as for treatment to any other joint in the body for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Treatment may be administered or prescribed by a Physician or dentist.

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

BENEFITS FOR SCALP HAIR PROSTHESIS

Benefits will be paid for scalp hair prostheses, including all equipment and accessories necessary for regular use of a scalp hair prosthesis, worn for hair loss suffered as a result of a health condition, including but not limited to alopecia areata or the treatment for cancer. The scalp hair prosthesis must be prescribed by a Physician. Benefits are limited to one scalp hair prosthesis per Policy Year, exclusive of any Deductible.

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

BENEFITS FOR PHENYLKETONURIA TREATMENT

Benefits will be paid the same as any other Sickness for special dietary treatment for phenylketonuria when recommended by a Physician.

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

BENEFITS FOR CYTOLOGIC SCREENING, MAMMOGRAPHIC EXAMINATIONS, OVARIAN CANCER SURVEILLANCE TESTS AND COLORECTAL SCREENING TESTS

Benefits will be paid the same as any other Sickness for routine screening procedures for cancer and the office or facility visit, including mammograms and Pap smears, surveillance tests for women who are at risk for ovarian cancer, and colorectal screening tests for men and women when ordered or performed by a Physician in accordance with the standard practice of medicine.

“At risk for ovarian cancer” means:

1. Having a family history:
 - a. With one or more first or second degree relatives with ovarian cancer.
 - b. Of clusters of women relatives with breast cancer.
 - c. Of nonpolyposis colorectal cancer.
2. Testing positive for BRCA1 or BRCA2 mutations.

“Surveillance tests for ovarian cancer” means annual screening using one of the following:

1. CA-125 serum tumor marker testing.
2. Transvaginal ultrasound.
3. Pelvic examination.
4. Other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

Benefits for preventive mammogram screening, including Digital Breast Tomosynthesis for Insureds At Risk for Breast Cancer, is covered as a Preventive Care Service.

“Digital breast tomosynthesis” means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

“At risk for breast cancer” means any of the following:

1. Having a family history with one or more first- or second-degree relatives with breast cancer.
2. Testing positive for BRCA1 or BRCA2 mutations.
3. Having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
4. Having a previous diagnosis of breast cancer.

Benefits include additional diagnostic services or testing after a mammogram when determined to be Medically Necessary by the Insured’s Physician. Additional testing shall not be subject to any Deductible, Copayment, or Coinsurance provisions of the Policy.

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

BENEFITS FOR RECONSTRUCTIVE SURGERY

Benefits will be paid the same as any other Injury or Sickness for reconstructive surgery when such service is incidental to or follows surgery resulting from Injury, Sickness or other diseases of the involved part or when such service is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician.

Benefits for reconstructive breast surgery following mastectomies must be provided if the mastectomy is Medically Necessary as determined by the attending Physician. Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a

symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and Insured.

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

BENEFITS FOR CONDITIONS CAUSED BY BREAST IMPLANTS

Benefits will be paid the same as any other Sickness for conditions caused solely by breast implants.

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

BENEFITS FOR DES RELATED CONDITIONS

Benefits will be paid the same as any other Sickness for conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

In the absence of credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no additional premium will be charged for such benefits.

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

BENEFITS FOR VENTILATOR DEPENDENCY

Benefits will be paid the same as any other Sickness for a maximum of 120 hours of services provided by a private duty nurse or personal care assistant to a ventilator-dependent person during the time the ventilator-dependent person is in a Hospital. The private duty nurse or personal care assistant shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of 120 hours maximum to assure adequate training of the Hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

BENEFITS FOR CHILD HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES

Benefits will be paid for the Allowed Amounts incurred for child health supervision services and prenatal care services exclusive of any Deductible, Copayment or other Coinsurance or dollar limitation requirements subject to the following guidelines.

Benefits shall be limited to one visit payable to one provider for all of the services provided at each visit subject to the schedule set forth below.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months old to 72 months old.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education and use of specialized skills and technology, when needed, as defined by Standards of Obstetric Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

BENEFITS FOR CLEFT LIP AND CLEFT PALATE

Benefits will be paid the same as any other Sickness for Dependent children under the limiting age for coverage for such Dependent, for Inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for Dependent children age 19 and over are limited to Inpatient and outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the Dependent child turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan or Pediatric Dental Services coverage provided under this Policy, the dental plan or coverage shall be primary and this coverage shall be secondary. Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this benefit.

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

BENEFITS FOR EMOTIONALLY DISABLED CHILDREN

Benefits will be paid the same as any other Sickness for an Emotionally Disabled Dependent Child for the treatment of an Emotional Disturbance in a residential treatment facility licensed by the commissioner of human services. "Emotionally disabled child" shall have the meaning set forth by the commissioner of human services in the rules and regulations relating to residential treatment facilities.

"Emotionally disabled Dependent child" means a Dependent child who is diagnosed with an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

1. Is detailed in a diagnostic codes list published by the commissioner.
2. Seriously limits a Dependent child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

"Emotional disturbance" is a generic term and is intended to reflect all categories of disorder described in the clinical code list published by the commissioner as "usually first evident in childhood or adolescence."

This mandatory coverage under Section 62A.151 of the Minnesota Insurance Laws shall be on the same basis as the inpatient Hospital medical coverage provided under the Policy.

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

BENEFITS FOR OUTPATIENT SERVICES IN LIEU OF HOSPITALIZATION

Benefits will be paid for the Covered Medical Expenses incurred for health care treatment or surgery performed on an outpatient basis at a facility equipped to perform these services in lieu of hospitalization whether or not the facility is part of a Hospital.

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.

The screening must consist at a minimum of a prostate-specific antigen blood test and a digital rectal examination.

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

BENEFITS FOR PRESCRIPTION DRUG COVERAGE FOR MENTAL ILLNESS

Benefits will be paid the same as any other Prescription Drug for antipsychotic drugs prescribed to treat Mental Illness.

If the Prescription Drug benefit utilizes a formulary, the following shall apply:

1. When the Physician prescribing the drug:
 - a. indicates to the dispensing pharmacist, orally or in writing that the Prescription Drug must be dispensed as communicated; and
 - b. certifies in writing to the Company that the Physician has considered all equivalent drugs in the Company's drug formulary and has determined that the drug prescribed will best treat the patient's condition.
2. When the Company receives a certification from the Physician as described above, the Company may not:
 - a. impose a special Deductible, Copayment, Coinsurance, or other special payment requirement that the Company does not apply to drugs that are in the Company's drug formulary; or
 - b. require written certification from the prescribing Physician each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.
3. Continuing care: Insureds receiving a prescribed drug to treat a diagnosed Mental Illness may continue to receive the prescribed drug for up to one year without the imposition of a special Deductible, Copayment, Coinsurance, or other special payment requirements, when the Company's drug formulary changes or an Insured changes health plans and the medication has been shown to effectively treat the Insured's condition.

In order to be eligible for this continuing care benefit:

- a. the Insured must have been treated with the drug for 90 days prior to a change in the Company's drug formulary or a change in the Insured's health plan.

- b. the Physician prescribing the drug indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated; and
- c. the Physician prescribing the drug certifies in writing to the Company that the drug prescribed will best treat the patient's condition.

The continuing care benefit shall be extended annually when the Physician prescribing the drug:

- a. indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated; and
 - b. certifies in writing to the Company that the drug prescribed will best treat the patient's condition.
4. Exception to formulary. The Company must promptly grant an exception to the health plan's drug formulary for an Insured when the Physician prescribing the drug indicates to the Company that:
- a. the formulary drug causes an adverse reaction in the Insured;
 - b. the formulary drug is contraindicated for the Insured; or
 - c. the Physician demonstrates to the Company that the Prescription Drug must be dispensed as written to provide maximum medical benefit to the Insured.

The Company is not required to provide coverage for a drug if the drug was removed from the Company's drug formulary for safety reasons.

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

BENEFITS FOR CANCER DRUG COVERAGE

Benefits will be paid the same as any other Prescription Drug for drugs for the treatment of cancer if the drug is recognized for treatment of cancer in one of the Standard Reference Compendia or in one article in Medical Literature.

"Standard reference compendia" means any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

"Off-label use of drugs" means when drugs are prescribed for treatments other than those stated in the labeling approved by the federal Food and Drug Administration.

"Medical literature" means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

Benefits include coverage of Medically Necessary services directly related to and required for appropriate administration of the cancer drug but does not include coverage of a drug not listed on the Company's drug formulary.

Benefits for orally administered anticancer medication will be paid on a basis no less favorable than intravenously administered or injected cancer medication.

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

BENEFITS FOR PORT-WINE STAINS

Benefits will be paid the same as any other Sickness for the elimination or maximum feasible treatment of port-wine stain for any Insured Person who is a resident of Minnesota.

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

BENEFITS FOR LYME DISEASE TREATMENT

Benefits will be paid the same as any other Sickness for Lyme disease treatment.

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

BENEFITS FOR COURT-ORDERED COVERAGE FOR MENTAL HEALTH SERVICES

For purposes of this section, mental health services means all Covered Medical Expenses that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are Covered Medical Expenses under the Policy or by law.

Benefits will be paid the same as any other Mental Illness for mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The Company must be given a copy of the court order and the behavioral care evaluation. The Company shall be financially liable for the evaluation if performed by a Preferred Provider and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is a Covered Medical Expense under the Policy and ordered to be provided by a Preferred Provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by the Company.

The Company may make a motion for modification of the court-ordered plan of care pursuant to the applicable rules of procedure for modification of the court's order. This motion may include a request for a new behavioral care evaluation.

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

BENEFITS FOR HEARING AIDS

Benefits will be paid the same as any other Sickness for the cost of hearing aids for hearing loss that is not correctable by other Covered Medical Expense procedures.

Benefits for the cost of hearing aids shall not exceed the cost of one hearing aid per ear every three years.

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

BENEFITS FOR CHEMICAL DEPENDENCY TREATMENT COVERAGE OF INSURED CONVICTED OF DRIVING WHILE IMPAIRED

For purposes of this section, chemical dependency treatment means all Covered Medical Expenses that are intended to treat chemical dependency and that are Covered Medical Expenses under the Policy or by law.

Benefits will be paid the same as any other Substance Use Disorder for chemical dependency treatment provided to an Insured by the Department of Corrections while the Insured is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense under section 169A.24 if: (1) a court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and (2) the Department of Corrections makes a determination based on a chemical assessment conducted while the Insured is in the custody of the department that treatment is appropriate. Treatment provided by the Department of Corrections that meets the requirements of this section shall not be subject to a separate medical necessity determination by the Company.

The Company must be given a copy of the court's preliminary determination and supporting documents and the assessment conducted by the Department of Corrections.

Payment rates for treatment provided by the Department of Corrections shall not exceed the lowest rate for outpatient chemical dependency treatment paid by the Company to a Preferred Provider.

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

BENEFITS FOR PRESCRIPTION EYE DROPS

Benefits will be paid the same as any other Prescription Drug for prescription eye drops as specified below.

The prescription eye drop refill will be covered if:

1. The refill is requested by the Insured as follows:
 - a. For a 30-day refill supply, the Insured makes the refill request between 21 and 30 days from the later of: 1) the original date the prescription was distributed to the Insured; or 2) the date the most recent refill was distributed to the Insured.

- b. For a 90-day refill supply, the Insured makes the refill request between 75 and 90 days from the later of: 1) the original date that the prescription was distributed to the Insured; or 2) the date the most recent refill was distributed to the Insured.
2. The Physician indicated on the original prescription that additional quantities are needed.
3. The refill requested by the Insured does not exceed the number of additional quantities needed.

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

BENEFITS FOR PANDAS AND PANS

Benefits will be paid the same as any other Sickness for PANDAS and PANS treatment. Treatment must be recommended by the Insured's Physician and includes but is not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

"Pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS)" means a condition in which streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

"Pediatric acute-onset neuropsychiatric syndrome (PANS)" means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

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

BENEFITS FOR POSTNATAL CARE

Benefits will be paid the same as any other Sickness for a Comprehensive Postnatal Visit.

"Comprehensive postnatal visit" means a visit with a Physician that includes a full assessment of the Insured mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

Benefits shall be provided for the following:

1. A comprehensive postnatal visit with a Physician not more than three weeks from the date of delivery.
2. Any postnatal visits recommended by a Physician between three (3) and eleven (11) weeks from the date of delivery.
3. A comprehensive postnatal visit with a Physician twelve (12) weeks from the date of delivery.

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

BENEFITS FOR GENDER AFFIRMING SERVICES

Benefits will be paid the same as any other Sickness for Medically Necessary Gender Affirming Services when provided by or under the direction of a Physician.

"Gender affirming services" means Covered Medical Expenses, including medical, surgical, counseling, referral, and telehealth services, that an Insured may receive to support and affirm that Insured's gender identity or gender expression and that are legal under the laws of the State of Minnesota.

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

BENEFITS FOR UNRESTRICTED ACCESS TO RARE DISEASE OR CONDITION SERVICES

Benefits will be paid the same as any other Sickness for unrestricted access to services from a Physician for the diagnosis, monitoring, and treatment of a Rare Disease or Condition.

"Rare disease or condition" means any disease or condition:

- That affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening.

- That affects more than 200,000 persons in the United States and a drug for treatment has been designated as such pursuant to United States Code, title 21, section 360bb.
- That is labeled as a rare disease or condition on the Genetic and Rare Disease Information Center list created by the National Institutes of Health.
- For which an Insured Person:
 - Has received two or more clinical consultations from a primary care provider or specialty provider that is specific to the presenting complaint.
 - Has documentation in the Insured Person's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement.
 - Had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

Any services received from, referred for, or ordered by an Out-of-Network Provider for an Insured Person who, before receiving and being notified of a definitive diagnosis, satisfied the requirements above shall be subject to the Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy even if the subsequent definitive diagnosis does not meet the definition of Rare Disease or Condition as noted above.

Once the Insured Person is definitively diagnosed with a disease or condition that does not meet the definition of Rare Disease or Condition as noted above, and notification of the diagnosis has been provided to both the Company and the Insured Person, or a parent or guardian of a minor, any services provided by, referred for, or ordered by an Out-of-Network Provider related to the diagnosis shall be subject to the Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy for up to 60 days, providing time for care to be transferred to a qualified Preferred Provider and to schedule needed Preferred Provider appointments. After this 60-day period, subsequent services provided by, referred for, or ordered by an Out-of-Network Provider related to the diagnosis shall be subject to the Out-of-Network Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

If the Insured receives services from an Out-of-Network Provider who is outside the State of Minnesota, the Insured could potentially be billed by the Out-of-Network Provider for an amount above what the Company is required to pay the Out-of-Network Provider, in accordance with Minnesota Statute Section 62Q.451, subd. 5.

A Rare Disease or Condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

This does not apply to medications obtained from a retail pharmacy.

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

BENEFITS FOR MATERNITY MEDICAL FACILITY TRANSFER

Effective January 1, 2025, benefits will be paid for expenses related to transferring the mother, Newborn, and Newborn siblings from one medical facility to a different medical facility when a Physician recommends that either the mother or Newborn be transferred to a different medical facility,

Benefits shall not be subject to any Deductible, Copayment, or Coinsurance provisions of the Policy.

BENEFITS FOR BIOMARKER TESTING

Effective January 1, 2025, benefits will be paid the same as any other Sickness for Biomarker Testing for the purposes of diagnosis, treatment, management, or ongoing monitoring of an Insured's Sickness or disease if the test provides Clinical Utility.

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarker includes, but is not limited to, gene mutations, characteristics of genes, or protein expression.

"Biomarker testing" means the analysis of an Insured's tissue, blood, or biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

Biomarker Testing will be covered when the test's

Clinical Utility may be demonstrated by medical and scientific evidence, including, but not limited to:

1. Nationally Recognized Clinical Practice Guidelines.
2. Consensus Statements.
3. Labeled indications for an FDA-approved or cleared test indicated for an FDA-approved drug, or adherence to warnings and precautions on FDA-approved drug labels.
4. Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.

"Clinical utility" means a test provides information that is used to formulate a treatment or monitoring strategy that informs an Insured's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.

"Consensus statement" means a statement that: (1) describes optimal clinical care outcomes, based on the best available evidence, for a specific clinical circumstance; and (2) is developed by an independent, multidisciplinary panel of experts that: (i) uses a rigorous and validated development process that includes a transparent methodology and reporting structure; and (ii) strictly adheres to the panel's conflict of interest policy.

"Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline that: (1) establishes a standard of care informed by (i) a systematic review of evidence, and (ii) an assessment of the risks and benefits of alternative care options; and (2) is developed by an independent organization or medical professional society that: (i) uses a transparent methodology and reporting structure; and (ii) adheres to a conflict of interest policy. Nationally recognized clinical practice guideline includes recommendations to optimize patient care.

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

BENEFITS FOR RAPID WHOLE GENOME SEQUENCING

Effective January 1, 2025, benefits will be paid the same as any other Sickness for Medically Necessary Rapid Whole Genome Sequencing for an Insured Person age 21 years of age or younger who has a complex or acute illness of unknown etiology that is not confirmed to have been caused by an environmental exposure, toxic ingestion, an infection with a normal response to therapy, or trauma, and is receiving inpatient hospital services in an intensive care unit or a neonatal or high acuity pediatric care unit

"Rapid whole genome sequencing" or "rWGS" means an investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. Rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the Insured and the Insured's biological parent or parents.

Coverage may be based on the following medical necessity criteria:

1. The Insured has symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if rWGS testing is not performed.
2. Timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the rWGS testing may aid in guiding the treatment or management of the Insured's condition.
3. The Insured's complex or acute Sickness of unknown etiology includes at least one of the following conditions:
 - Congenital anomalies involving at least two organ systems, or complex or multiple congenital anomalies in one organ system.
 - Specific organ malformations that are highly suggestive of a genetic etiology.
 - Abnormal laboratory tests or abnormal chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism.
 - Refractory or severe hypoglycemia or hyperglycemia.
 - Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems.
 - Severe muscle weakness, rigidity, or spasticity.
 - Refractory seizures.
 - A high-risk stratification on evaluation for a brief resolved unexplained event with any of the following features:
 - A recurrent event without respiratory infection.
 - A recurrent seizure-like event.
 - A recurrent cardiopulmonary resuscitation.
 - Abnormal cardiac diagnostic testing results that are suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease.
 - Abnormal diagnostic imaging studies that are suggestive of underlying genetic condition.
 - Abnormal physiologic function studies that are suggestive of an underlying genetic etiology.

- Family genetic history related to the patient's condition.

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

BENEFITS FOR ORTHOTIC AND PROSTHETIC DEVICES

Effective January 1, 2025, benefits will be paid the same as any other Sickness for Medically Necessary Orthotic and Prosthetic devices, supplies, and services, including repair and replacement.

Benefit include Medically Necessary Orthosis and Prothesis and any provision, repair, or replacement of a device that is furnished or performed by an Accredited Facility in comprehensive orthotic services or a provider.

Benefits also include coverage for the replacement of Prosthetic or Orthotic device or for the replacement of any part of the devices, without regard to continuous use or useful lifetime restrictions, if an ordering Physician determines that the replacement device or replacement part is necessary because:

1. Of a change in the physiological condition of the Insured.
2. Of an irreparable change in the condition of the device or in a part of the device.
3. The condition of the device or the part of the device requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

“Accredited Facility” means any entity that is accredited to provide comprehensive Orthotic or Prosthetic devices or services by a Centers for Medicare and Medicaid Services approved accrediting agency.

“Orthotics” means all the following:

1. The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing and providing the initial training necessary to accomplish the fitting of an orthotic device for the support, correction, or alleviation of a neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity.
2. Evaluation, treatment, and consultation related to an orthotic device.
3. Basic observation of gait and postural analysis.
4. Assessing and designing Orthosis to maximize function and provide support and alignment necessary to prevent or correct a deformity or to improve the safety and efficiency of mobility and locomotion.
5. Continuing Insured care to assess the effect of an orthotic device on the Insured's tissues.
6. Proper fit and function of the orthotic device by periodic evaluation.

"Orthosis" means:

1. An external medical device that is:
 - Custom-fabricated or custom-fitted to a specific Insured based on the Insured's unique physical condition.
 - Applied to a part of the body to correct a deformity, provide support and protection, restrict motion, improve function, or relieve symptoms of a disease, syndrome, Injury, or postoperative condition.
 - Deemed to be Medically Necessary by a Physician who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services.
2. Any provision, repair, or replacement of a device that is furnished or performed by:
 - An Accredited Facility in comprehensive Orthotic services.
 - A Physician licensed in Minnesota and operation within their scope of practice which allows for the provision of Orthotic or Prosthetic devices, supplies, or services.

“Prosthetics” means:

1. The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities or absences.
2. The generation of an image, form, or mold that replicates the Insured's body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to create an artificial appendage that is designed either to support body weight or to improve or restore function of anatomical appearance, or both.
3. Observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize function, stability, and safety of the Insured.
4. Providing and continuing Insured care in order to assess the prosthetic devices' effect on the Insured's tissues.
5. Assuring proper fit and function of the prosthetic device by periodic evaluation.

"Prosthesis" means:

1. An external medical device that is:

- Used to replace or restore a missing limb, appendage, or other external human body part.
- Deemed to be Medically Necessary by a Physician who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services.
 2. Any provision, repair, or replacement of a device that is furnished or performed by:
 - An Accredited Facility in comprehensive Orthotic services.
 - A Physician licensed in Minnesota and operation within their scope of practice which allows for the provision of Orthotic or Prosthetic devices, supplies, or services.

Nondiscrimination Standard for Coverage:

Benefits for Prosthetics and Orthotics shall be provided in a nondiscriminatory manner and shall not deny coverage solely on the basis of an Insured’s actual or perceived disability.

Benefits shall not be denied for a Prosthetic or Orthotic for an Insured with a limb loss or absence that would otherwise be covered for a nondisabled Insured seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

In the event that Medically Necessary covered Orthotics and Prosthetics are not available from a Preferred Provider, the Company shall provide processes to refer an Insured to an Out-of-Network Provider and shall reimburse the Out-of-Network Provider at a mutually agreed upon rate less Insured cost-sharing determined on Preferred Provider rate.

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

BENEFITS FOR INTERMITTENT CATHETERS

Effective January 1, 2025, benefits will be paid for up to 180 intermittent catheters and insertion supplies per month if recommended by the Insured’s Physician.

Benefits shall be subject to any 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.
- The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.
- 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:

- 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.

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: Definitions

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 certain Preferred Provider facilities from Out-of-Network Provider Physicians** when such services are either: a) Ancillary Services; or b) 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)*.

For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1)

of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary.

2. 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.

3. For Air Ambulance transportation 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.

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.

ANCILLARY SERVICES means items and services provided by Out-of-Network Provider Physicians at a Preferred Provider facility that are any of the following:

1. Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
2. Provided by assistant surgeons, hospitalists, and intensivists.
3. Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary.
4. Provided by such other specialist practitioners as determined by the Secretary.
5. Provided by an Out-of-Network Provider Physician when no other Preferred Provider Physician is available.

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

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

DEPENDENT means the legal spouse of the Named Insured and their dependent children. Coverage shall be provided on the same basis as other dependents for disabled children, adopted children, and children for whom the Named Insured or the Named Insured's spouse has been appointed legal guardian. Coverage for adopted children is effective from the date of placement without the application of any insurability requirements and continues unless the child is removed from placement prior to legal adoption. Disabled dependents (spouse and dependent children) may be added at any time and will be accepted without the application of any pre-existing condition limitation or insurability requirements. Dependent children are not required to reside with the Insured. A grandchild who is financially dependent upon an Insured grandparent and who resides with that Insured grandparent continuously from birth is a dependent.

Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

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

1. Incapable of self-sustaining employment by reason of developmental disability, Mental Illness, 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 not more frequently than annually after the two-year period following the child's attainment of the limiting age.

The Insured Person must establish within 31 days of the limiting age that the child is and continues to be disabled in order to avoid a claim delay or denial.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that are not Medically Necessary for the treatment of a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are Experimental or Investigational Services; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means, with respect to a Medical Emergency, both:

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)).

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 each of the following conditions are met:

1. 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.
2. The provider furnishing the additional items and services satisfied the notice and consent criteria in accordance with applicable law.
3. The patient is in such a condition to receive information as stated in 2 above and to provide informed consent in accordance with applicable law.
4. The provider or facility satisfied any additional requirements or prohibitions as may be imposed by state law.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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, except for Covered Medical Expenses under Approved Clinical Trials in the Medical Expense Benefits section.

The following are considered exceptions to Experimental or Investigational Services:

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

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

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

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

HOSPITAL means a licensed or properly accredited general hospital which 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.

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 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 the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

1. Placement of the Insured's health in jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any body 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. The presenting symptoms are taken into consideration, not solely the actual diagnosis, when paying expenses for Medical Emergency.

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

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

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

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

With respect to Mental Illness, Medical Necessity means those services appropriate, in terms of type, frequency, level, setting, and duration, to the Insured's diagnosis or condition, and diagnostic testing and preventive services. Medically Necessary Mental Illness services must be consistent with generally accepted practice parameters as determined by a Physician in the same or similar general specialty as typically manages the Mental Illness condition, procedure, or treatment at issue and must meet one of the following requirements:

1. Help restore or maintain the Insured's health.
2. Prevent the deterioration of the Insured's condition.

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.

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

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

NEWBORN INFANT means any child born of an Insured while that person is insured under the Policy. A newborn will be covered immediately from birth. Newborn infant includes a newborn grandchild who is financially dependent upon an Insured grandparent and who resides with that Insured grandparent continuously from birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed Congenital Conditions, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will be responsible for any additional required premium for the coverage. Uncollected past due premium will be deducted from claim payments.

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.

PHYSICIAN means a duly qualified licensed physician, physician assistant, advanced practice registered nurse, pharmacist, or any other provider of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws, other than a member of the person's immediate family.

The term "member of the immediate family" means husband, wife, children, father, mother, brother, sister, and the corresponding in-laws.

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.

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 certain Preferred Provider facilities by Out-of-Network Provider Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Health Service Act*. For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

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.

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.

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

TELEHEALTH means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes:

1. The application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site.
2. Audio-only communication between a health care provider and a patient. A communication between a licensed health care provider and patient that consists solely of an e-mail or facsimile transmission does not constitute telehealth consultations or services.
3. Remote telemonitoring of clinical data related to the Insured's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a Physician for analysis. Telemonitoring is intended to collect an Insured's health-related data for the purpose of assistance a Physician in assessing and monitoring the Insured's medical condition or status.

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

Section 10: Exclusions and Limitations

This Exclusions and Limitations section describes items which are excluded from coverage and are not considered to be Covered Medical Expenses.

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

1. Acupuncture.
2. Addiction, such as:
 - Caffeine addiction.
 - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
 - Codependency.
3. Behavioral problems, except as defined as a Mental Illness. Developmental delay or disorder or intellectual disability. Learning disabilities. Milieu therapy. Parent-child problems. This exclusion does not apply to benefits specifically provided for the treatment of a Mental Illness or Substance Use Disorder as defined in the Policy in the Definitions section.
4. Circumcision.
5. Cosmetic procedures, except reconstructive procedures to:
 - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
 - Remove port wine stains.
 - As described under Benefits for Reconstructive Surgery in the Policy Mandated Benefits section.This exclusion does not apply to Medical Emergency complications from cosmetic surgery.
6. Custodial Care or domiciliary care provided in any type of facility.
7. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 - As specifically provided in the Schedule of Benefits under Dental Treatment.
 - As described under Dental Treatment in the Policy in the Medical Expense Benefits section.This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment as defined in the Policy in the Definitions section. This exclusion does not apply to:
 - Benefits for Reconstructive Surgery in the Policy Mandated Benefits section.
 - Cosmetic procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy where the primary result of the procedure is not a changed or improved physical appearance.
 - Removal of port wine stains.
9. Elective abortion. This exclusion does not apply when the life of the mother is at risk.
10. Foot care for the following:

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

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.

11. Genetic testing, except as specifically provided in the Policy in the Medical Expense Benefits section under the Genetic Testing benefit.

12. Health spa or similar facilities. Strengthening programs.

13. 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.
- External hearing aids or bone anchored hearing aids once every three years for an Insured Person with a hearing loss that is not correctable by other services provided in the Policy.
- Benefits specifically provided in the Policy in the Schedule of Benefits.

14. Hirsutism.

15. Hypnosis.

16. Immunizations that are not specifically covered by the Policy under Preventive Care Services in the Medical Expense Benefits section and under Benefits for Child Health Supervision Services and Prenatal Care Services in the Mandated Benefits section. Medicines or vaccines that are not required for the treatment of a covered Injury or are not specifically covered by the Policy under Preventive Care Services in the Medical Expense Benefits section and under Benefits for Child Health Supervision Services and Prenatal Care Services in the Mandated Benefits section.

17. Injury sustained from playing, practicing, traveling to or from, or participating in, or conditioning for any intercollegiate sport for which benefits are paid under a sports accident policy issued to the Policyholder, or for which coverage is paid by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletics (NAIA) or any other sports association.

18. Experimental or Investigational Services.

19. Lipectomy.

20. Commission of or attempt to commit a felony.

21. Prescription Drugs, services or supplies as follows:

- Prescription drug related therapeutic devices or appliances, including: hypodermic needles and syringes, this exclusion does not apply to the treatment of diabetes. support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy in the Medical Expense Benefits section and Mandated Benefits section.
- Immunization agents, except as specifically provided in the Policy under Preventive Care Services in the Medical Expense Benefits section and Benefits for Child Health Supervision Services and Prenatal Care Services in the Mandated Benefits section.
- Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in Benefits for Cancer Drug Coverage.
- Products used for cosmetic purposes.
- Drugs used to treat or cure baldness. Anabolic steroids used for body building.
- Anorectics - drugs used for the purpose of weight control.
- Fertility agents or sexual enhancement drugs.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

22. Reproductive services for the following:

- Procreative counseling.
- Genetic counseling and genetic testing, except as specifically provided in the Policy in the Medical Expense Benefits section under the Genetic Testing benefit.
- 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 the underlying cause of the infertility.
- Premarital examinations.
- Impotence, organic or otherwise.
- Female sterilization procedures, except as specifically provided in the Policy under Preventive Care Services in the Medical Expense Benefits section.
- Vasectomy.

- Reversal of sterilization procedures.
23. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy under Approved Clinical Trials in the Medical Expense Benefits section.
 24. 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 the initial evaluation, fitting, and initial pair of eyeglasses or contact lenses for: a) the post-operative treatment of cataracts; and b) the treatment of aphakia or keratoconus.
 25. Services provided without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
 26. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except as provided for Benefits for Temporomandibular Joint Disorder and Craniomandibular Disorder and as provided for Benefits for Cleft Lip and Cleft Palate. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
 27. Sleep disorders.
 28. Speech therapy, except as covered in the Physiotherapy and Habilitative Services benefits in the Medical Expense Benefits section of the Policy.
 29. Supplies available over-the-counter (examples include cotton balls, cotton swabs, bandages that are available without a prescription).
This exclusion does not apply to Medically Necessary supplies listed in the following Covered Medical Expenses:
 - Hospital Miscellaneous Expenses.
 - Day Surgery Miscellaneous.
 - Medical Emergency Expenses.
 - Diabetes Services.
 30. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as provided in the Reconstructive Breast Surgery Following Mastectomy, Benefits for Reconstructive Surgery, and Benefits for Conditions Caused by Breast Implants provisions in the Policy.
 31. Services for which the Insured Person is not expected to pay for such services.
 32. Active participation in any war or any act of war, declared or undeclared, while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered). This exclusion does not apply to an Insured civilian who is injured or otherwise affected by war, any act of war, or an act of terrorism in non-war zones.
 33. Weight management. Weight reduction. Nutrition programs, except Medically Necessary programs provided to an Insured Person with a medical condition such as diabetes, phenylketonuria or a Mental Illness eating disorder. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in Preventive Care Services.

Section 11: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or 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 or university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

If 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 12: 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, during which grace period the Policy shall continue in force subject to the right of the Company to cancel in accordance with Section 2: Effective and Termination Dates.

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.

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

CONTINUATION OF COVERAGE FOR SURVIVORS: This Policy shall not terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under this Policy to the survivor or survivors of the Named Insured until the earlier of the following dates: (1) the date the surviving spouse becomes covered under another group health plan; or (2) the date coverage would have terminated under this Policy had the Named Insured lived.

Any required premium for the coverage shall be paid by the survivor to the Policyholder for remittance to the Company. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and Dependent children who are not the survivors of a deceased Named Insured. Failure of the survivor to make premium payments within 90 days after notice of the requirement to pay the premiums shall be a basis for the termination of the coverage without written consent. In the event of termination by reason of the survivor's failure to make the required premium payments, written notice of cancellation will be mailed to the survivor's last known address at least 30 days before the cancellation.

CONTINUATION OF FAMILY COVERAGE PRIVILEGE: Continuation of coverage shall be permitted under this Policy for: 1) the Named Insured's spouse and Dependent children when the Named Insured becomes enrolled for benefits under Title XVII of the Social Security Act (Medicare); and 2) the Named Insured's Dependent children when they cease to be Dependent as defined in this Policy.

The coverage may be continued until the earlier of the following dates: 1) the date coverage would otherwise terminate under this Policy; 2) the date the Named Insured's spouse or Dependent Children become covered under another group health plan; 3) 36 months after continuation by the spouse or dependent was elected.

Any required premium for the coverage shall be paid by the Insured to the Policyholder for remittance to the Company. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and Dependent children to whom this provision is not applicable.

CONTINUATION OF COVERAGE FOR FORMER SPOUSE AND CHILDREN: Continuation of coverage shall be permitted under this Policy for the Named Insured's Dependent children and the Named Insured's former spouse, who was covered on the day before the entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates: (a) the date the Named Insured's former spouse becomes covered under any other group health plan; or (b) the date coverage would otherwise terminate under this Policy.

Any required premium for the coverage shall be paid by the Insured to the Policyholder for remittance to the Company. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and Dependent children with respect to whom the marital relationship has not dissolved.

REINSTATEMENT: If any renewal premium be not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. If the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following

the date of such conditional receipt unless the Company has previously notified the Insured in writing of its disapproval of such application.

ENTIRE CONTRACT CHANGES: This Policy, including the Certificate of Coverage, Schedule of Benefits, Endorsements, Policyholder Application, and attached papers, if any, shall constitute the entire contract between the parties. No agent has authority to change this Policy or to waive any of its provisions. No change in the Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an Endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the Policyholder in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such two year period.

Section 13: Complaint Resolution

An Insured Person may submit a Complaint either orally or in writing to the Company.

Please contact the Customer Service Department at the number located on the Insured's ID card with any questions regarding the Complaint Resolution process. The written request for Complaint Resolution should be sent to: UnitedHealthcare Student Resources, PO Box 809025, Dallas, TX 75380-9025.

At any time an Insured Person has the right to contact the Commissioner's office to submit the Complaint for investigation. The quickest and most efficient way to file a complaint is through our online portal.

Phone: 1-800-657-3602

On-Line complaints: <https://mn.gov/commerce/consumers/file-a-complaint/>

Email: consumer.protection@state.mn.us

For a Complaint submitted orally, the Company will notify the Insured Person within 10 days of receiving the Complaint that the Complaint may be submitted in writing if the determination is partially or wholly adverse to the Insured Person or not resolved to the satisfaction of the Insured Person. The Company will provide the Insured Person with assistance needed to submit a written Complaint, including an offer to complete the complaint form for the Complaint that was previously submitted orally and promptly mail the complete form to the Insured Person for the Insured's signature.

Upon receipt of a written Complaint, the Company will notify the Insured Person within 10 business days that the Complaint was received, unless the Complaint is resolved to the satisfaction of the Insured Person within the 10 business days. Upon request, assistance in submitting a written Complaint is available from the Company.

The Company will notify the Insured Person in writing of its determination and the reasons for it no later than 30 days after receipt of the written Complaint. If the Company cannot make a decision within 30 days due to circumstances outside the control of the Company, the Company may take up to 14 additional days to notify the Insured Person of its decision. If the Company takes any additional days beyond the initial 30 day period to make its decision, the Company will inform the Insured Person, in advance, of the extension and the reasons for the extension.

The Company will notify the Insured Person in writing of its determination and the reasons no later than 45 days after the receipt of a complaint appeal by hearing.

If the decision is partially or wholly adverse to the Insured Person, a description of the procedures for the right to appeal the decision through the Company's internal appeal process will be provided to the Insured Person. Notice of the Insured Person's right to contact the Commissioner's office at 1-800-657-3602 or ombudsman's office for assistance with respect to submitting the Complaint at any time will be included.

COMPLAINT RESOLUTION DEFINITION

For the purpose of this Complaint Resolution, the following term is defined as shown below:

Complaint means any grievance against the Company that is not the subject of litigation and has been submitted by the Insured Person to the Company regarding the provision of health services, including, but not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, or cancellations; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered.

Section 14: Standard Utilization Review Request

When the Company receives all information reasonably necessary to make a determination, then standard review determinations on all requests for Utilization Review must be communicated to the Physician and Insured within five business days after the Company's receipt of the request.

If the determination is made to authorize the request, then the Company must promptly notify the Physician by telephone. The Company will follow-up with a written notification to the Physician and shall maintain an audit trail of the determination and the telephone notification. "Audit trail" includes documentation of the telephone notification, including date, name of person spoken to, name of Insured, the date and type of service, procedure or admission that was authorized. For the purpose of this section, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Electronic forms of notification satisfy the audit trail requirements.

UTILIZATION REVIEW DEFINITION

For the purpose of a standard Utilization Review request, the following term is defined as shown below:

Utilization Review means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending Physician, for the purpose of determining the Medical Necessity of the service or admission. Utilization review also includes prior authorization and review conducted after the admission of the Insured. It includes situations where the Insured is unconscious or otherwise unable to provide advance notification. Utilization review does not include a referral or participation in a referral process by a Participating Provider unless the provider is acting as a utilization review organization

Section 15: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL

Standard Internal Appeal

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

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at the number on the Insured's ID card with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare Student Resources, PO Box 809025, Dallas, TX 75380-9025.

Internal Appeal Process

Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination.

Upon receipt of the request for an Internal Review, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination.

Within three working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:

1. Any new or additional evidence considered by the Company in connection with the grievance; and
2. Any new or additional rationale upon which the decision was based.

The Insured Person or Authorized Representative shall have 10 calendar days to respond to any new or additional evidence or rationale.

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative as follows:

1. For a Prospective Review, the notice shall be made no later than 15 days after the Company's receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 15 days after the Company's receipt of the grievance.

Time periods shall be calculated based on the date the Company receives the request for the Internal Review, without regard to whether all of the information necessary to make the determination accompanies the request.

The written notice of Final Adverse Determination for the Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
 - a. The date of service;
 - b. The name health care provider; and
 - c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
 - a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
 - b. Reference to the specific Policy provisions upon which the determination is based;
 - c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
 - d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
 - e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
 - f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
7. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

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

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

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

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

Expedited Internal Review Process

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

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

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Authorized Representative shall be notified of the EIR decision no more than forty-eight (48) hours (and the 48 hour period includes at least one business day) after the Company's receipt of the EIR request.

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

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

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

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

RIGHT TO EXTERNAL INDEPENDENT REVIEW

After exhausting the Company's Internal Appeal process, an Insured Person or Authorized Representative may submit a request for an External Independent Review when the service or treatment in question:

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

A request for an External Independent Review shall not be made until the Insured Person or Authorized Representative has exhausted the Internal Appeals process. The Internal Appeal Process shall be considered exhausted if:

1. The Company has issued a Final Adverse Determination as detailed herein;
2. The Insured Person or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the Company within 30 days and the Insured Person or Authorized Representative has not requested or agreed to a delay;
3. The Company fails to strictly adhere to the Internal Appeal process detailed herein; or
4. The Company agrees to waive the exhaustion requirement.

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has six months to request an External Independent Review. The request for an External Review should be made in writing to the Commissioner. Upon request of an External Review, the Commissioner shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

Where to Send External Review Requests

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

Minnesota Department of Commerce
Attn: Consumer Protection & Education Division
85 7th Place East, Suite 280
St. Paul, MN 55101

Standard External Review (SER) Process

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

Nothing requires the Commissioner to independently investigate an Adverse Determination or Final Adverse Determination referred for External Independent Review.

1. Upon receiving a request for an External Review, the Commissioner shall assign an Independent Review Organization (IRO) on a random basis. The assigned IRO must provide immediate notice of the review to the Insured and the Company.
 - a. Within 10 business days of receiving notice of the review, the Company and the Insured must provide the IRO with any information that is required.
 - b. The IRO must furnish to the Company any additional information submitted by the Insured within one business day of receipt.

As part of the External Review process, any aspect of an External Review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed.

The IRO and the clinical reviewer assigned must not have a material professional, familial, or financial conflict of interest with: (1) the Company; (2) the Insured; (3) any officer, director or management employee of the Company; (4) a plan administrator, plan fiduciaries, or plan employees; (5) the health care provider, the health care provider's group, or practice association recommending treatment that is the subject of the External Review; (6) the facility at which the recommended treatment would be provided; or (7) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

2. Within 45 days after receipt of the External Review request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

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

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Commissioner at the time the Insured Person receives:
 - a. An Adverse Determination if:
 - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
 - The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - b. A Final Adverse Determination, if:
 - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received Emergency Services, but has not been discharged from a facility.

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

2. Upon receipt of an EER request, the Commissioner shall immediately send a copy of the request to the Company.
3. Upon receipt of a request for an EER, the Company shall immediately review the request to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
 - c. The Insured Person has provided all the information and forms necessary to process the request; and
 - d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
4. Immediately after completion of the review, the Company shall notify the Commissioner, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;

- b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
5. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an Independent Review Organization (IRO) from the Commissioner's approved list and notify the Company of the name of the assigned IRO.
 - a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
 - b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6.
 - a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
7. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
 - a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
 - b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.
8. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Standard Experimental or Investigational Treatment External Review (SEIER) Process

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

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

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Commissioner.
2. Upon receipt of an SEIER request, the Commissioner shall immediately send a copy of the request to the Company.
3. Within five business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
 - b. The recommended or requested health care services or treatment:
 - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - Standard health care services or treatments are not medically appropriate for the Insured Person;
 - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
 - d. The Insured Person's treating Physician:
 - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. The Insured Person has exhausted the Company's Internal Appeal Process; and
 - f. The Insured Person has provided all the information and forms necessary to process the request.

4. Within one business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
 - b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
5. After receiving notice that a request is eligible for SEIER, the Commissioner shall, within one business day:
 - a. Assign an IRO from the Commissioner's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within five business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
6.
 - a. The Company shall, within five business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SEIER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
7. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
8. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
 - b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
9. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational Treatment External Review (EEIER) Process

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

1. An Insured Person or an Authorized Representative may make an oral request for an Expedited Experimental or Investigational Treatment External Review (EEIER) with the Commissioner at the time the Insured Person receives:
 - a. An Adverse Determination if:
 - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
 - The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or
 - b. A Final Adverse Determination, if:
 - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

An EEIER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.
2. Upon receipt of an EEIER request, the Commissioner shall immediately send a copy of the request to the Company.

3. Upon receipt of an EEIER request notice, the Company shall immediately complete a preliminary review to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
 - b. The recommended or requested health care services or treatment:
 - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - Standard health care services or treatments are not medically appropriate for the Insured Person;
 - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
 - d. The Insured Person's treating Physician:
 - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. The Insured Person has exhausted the Company's Internal Appeal Process unless the Insured person is not required to do so as specified in sub-sections 1. a. and b. above; and
 - f. The Insured Person has provided all the information and forms necessary to process the request.
4. The Company shall immediately notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for an EEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
5. After receiving notice that a request is eligible for EEIER, the Commissioner shall immediately:
 - a. Assign an IRO from the Commissioner's approved list; and
 - b. Notify the Company of the name of the assigned IRO.
6. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
7.
 - a. If the EEIER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EEIER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EEIER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EEIER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
8.
 - a. The Company shall, within five business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the EEIER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
9. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
10. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the EEIER.
 - b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.

- c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
- 11. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than five calendar days after being selected by the IRO.
- 12. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
- 13. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

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

APPEAL RIGHTS DEFINITIONS

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

Adverse Determination means:

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

Authorized Representative means:

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

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

Final Adverse Determination means an Adverse Determination involving a Covered Medical Expense that has been upheld by the Company, at the completion of the Company's internal appeal process or an Adverse Determination for which the internal appeals process has been deemed exhausted in accordance with this notice.

Prospective Review means Utilization Review performed: 1) prior to an admission or the provision of a health care service or course of treatment; and 2) in accordance with the Company's requirement that the service be approved, in whole or in part, prior to its provision.

Retrospective Review means any review of a request for a Covered Medical Expense that is not a Prospective Review request. Retrospective review does not include the review of a claim that is limited to the veracity of documentation or accuracy of coding.

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

- 1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or

2. In the opinion of a physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review

Questions Regarding Appeal Rights

Contact Customer Service at the number on the Insured's ID card with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Section 16: 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 17: 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 18: 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 19: 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

Located on the Insured's ID card

Website: www.uhcsr.com

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))

Section 20: Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and 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 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.

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.

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 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 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.)		
<p><i>Evaluations (Checkup Exams)</i></p> <p>Limited to two times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.</p> <p>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</p>	50%	50%
<p><i>Intraoral Radiographs (X-ray)</i></p> <p>Limited to one series of films per 36 months.</p> <p>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 D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only</p>	50%	50%
<p>The following services are limited to two per 12 months.</p> <p>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</p>	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
D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only		
Any combination of the following services is limited to two series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two 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%
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.)		
<i>Dental Prophylaxis (Cleanings)</i>	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 limited to two times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child		
<i>Fluoride Treatments</i> The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride - excluding varnish	50%	50%
<i>Sealants (Protective Coating)</i> The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	50%	50%
<i>Space Maintainers (Spacers)</i> The following services are not subject to a frequency limit. 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 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	50%	50%
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
<i>Amalgam Restorations (Silver Fillings)</i>	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
<p>The following services are not subject to a frequency limit.</p> <p>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</p>		
<p><i>Composite Resin Restorations (Tooth Colored Fillings)</i></p> <p>The following services are not subject to a frequency limit.</p> <p>D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior)</p>	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
<p>The following services are subject to a limit of one time every 60 months.</p> <p>D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces 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</p>	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
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 service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair 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 services are not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration) D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration)	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
D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)		
The following services are not subject to a frequency limit. D3310 - Endodontic therapy, anterior tooth (excluding final restoration) D3320 - Endodontic therapy, premolar tooth (excluding final restoration) D3330 - Endodontic therapy, molar tooth (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar	50%	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit	50%	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy - premolar (first root) D3425 - Apicoectomy - molar (first root) D3426 - Apicoectomy (each additional root) D3450 - Root amputation - per root D3471 - Surgical repair of root resorption - anterior D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	50%	50%
The following services are not subject to a frequency limit.	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
D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy		
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one every 36 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 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	50%	50%
The following services are limited to one every 36 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 D4263 - Bone replacement graft retained natural tooth - first site in quadrant D4286 - Removal of non-resorbable barrier	50%	50%
The following service is not subject to a frequency limit. 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	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
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 D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns		
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 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	50%	50%
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50%	50%
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 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)	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
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) 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	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
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 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 12 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)	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
D5876 - Add metal substructure to acrylic full denture (per arch)		
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%
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 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	50%	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are 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	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
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		
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%
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	50%	50%
The following services are not subject to a frequency limit.	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
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		
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit. 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%
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.	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
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. 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) D6062 - Abutment supported cast metal crown (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
<p>D6063 - Abutment supported cast metal crown (predominately base metal)</p> <p>D6064 - Abutment supported cast metal crown (noble metal)</p> <p>D6065 - Implant supported porcelain/ceramic crown</p> <p>D6066 - Implant supported crown - porcelain fused to high noble alloys</p> <p>D6067 - Implant supported crown - high noble alloys</p> <p>D6068 - Abutment supported retainer for porcelain/ceramic FPD</p> <p>D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal)</p> <p>D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)</p> <p>D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal)</p> <p>D6072 - Abutment supported retainer for cast metal FPD (high noble metal)</p> <p>D6073 - Abutment supported retainer for cast metal FPD (predominately base metal)</p> <p>D6074 - Abutment supported retainer for cast metal FPD (noble metal)</p> <p>D6075 - Implant supported retainer for ceramic FPD</p> <p>D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys</p> <p>D6077 - Implant supported retainer for metal FPD - high noble alloys</p> <p>D6080 - Implant maintenance procedure</p> <p>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</p> <p>D6082 - Implant supported crown - porcelain fused to predominantly base alloys</p> <p>D6083 - Implant supported crown - porcelain fused to noble alloys</p> <p>D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys</p> <p>D6086 - Implant supported crown - predominantly base alloys</p> <p>D6087 - Implant supported crown - noble alloys</p> <p>D6088 - Implant supported crown - titanium and titanium alloys</p>		

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
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 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		
The following services are not subject to a frequency limit.	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
D6105 - Removal of implant body not requiring bone removal or flap elevation D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, 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%
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
<p>Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically debilitating malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.</p> <p>All orthodontic treatment must be prior authorized.</p> <p>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.</p> <p>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.</p>		
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 D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment	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
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		

Section 3: Pediatric Dental Exclusions

These exclusions apply specifically to Pediatric Dental benefits included in this provision. They do not apply to any Covered Medical Expenses provided elsewhere in the Policy.

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. 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.
8. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
9. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
10. 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.
11. 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.
12. Dental 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. Benefits are available for temporomandibular joint disorder and craniomandibular disorder in the medical expense benefits portion of this Policy under the Mandated Benefit titled "Benefits for Temporomandibular Joint Disorder and Craniomandibular Disorder."
13. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
14. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this section of the Policy.
15. 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.
16. 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.
17. Foreign Services are not covered unless required for a Dental Emergency.

18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
20. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. 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. Benefits are available for temporomandibular joint disorder and craniomandibular disorder in the medical expense benefits portion of this Policy under the Mandated Benefit titled "Benefits for Temporomandibular Joint Disorder and Craniomandibular Disorder."

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 section.

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 section 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 section. The definition of Necessary used in this section relates only to benefits under this section 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.

Section 21: Pediatric Vision Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a 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 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 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 applies to the Out-of-Pocket Maximum stated in the Policy Schedule of Benefits.

Policy Deductible

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

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.

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 determination will be made by the Vision Care Provider and not by the Company.

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

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Schedule of Benefits

Vision Care Service	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.		
• Single Vision		100% after a Copayment of \$40.	50% of the billed charge.
• Bifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Trifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Lenticular		100% after a Copayment of \$40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to \$130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - \$160.		100% after a Copayment of \$15.	50% of the billed charge.

• Eyeglass frames with a retail cost of \$160 - \$200.		100% after a Copayment of \$30.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - \$250.		100% after a Copayment of \$50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.		60%	50% of the billed charge.
Contact Lenses Fitting & Evaluation	Once per year.	100%	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 under Section 1: Benefits for Pediatric Vision Care Services, benefits are not provided for the following:

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

Section 22: 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 section.

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.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after $\frac{3}{4}$ of the original Prescription Drug Product has been used. For select controlled medications filled at a retail Network Pharmacy, refills are available when 90% of the original Prescription Drug Product has been used. For select controlled medications filled at a mail order Network Pharmacy, refills are available when 80% of the original Prescription Drug Product has been used.

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 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 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.

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 that contain insulin and are used to treat diabetes, Insured Persons payment will not exceed the net price of the 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 or by calling Customer Service at 1-855-828-7716.

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 or by calling Customer Service at 1-855-828-7716.

When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay the same Copayment and/or Coinsurance as the Preferred Specialty Network Pharmacy.

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 the same Copayment and/or Coinsurance as the Preferred Specialty Network Pharmacy 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 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 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.

The Insured and the Insured's Physician may find out whether a Prescription Drug Product is subject to step therapy requirements, and may also review the step therapy override process, by accessing the Company's website at www.uhcsr.com or by calling Customer Service at 1-855-828-7716.

When a step therapy requirement applies to a Prescription Drug Product, the Insured's Physician may request an exception:

- For non-urgent step therapy exception requests, a review will be completed within five (5) days once all information needed to process the request has been received.

- For urgent step therapy requirements, a review will be completed within 72 hours once all the information needed to process the request has been received.
- If the Insured's step therapy request is denied, the decision will specifically state why it was denied. The Insured may refer to Section 15 Notice of Appeal Rights for additional information on appealing an adverse determination.

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 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 Insured.

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

NOTE: The tier 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 or call Customer Service at 1-855-828-7716 for the most up-to-date tier placement.

Rebates and Other Payments

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

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. 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 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) and ending on the earlier of the following dates:

- The date it is placed on a tier by the Company's PDL Management Committee.
- December 31st of the following calendar year.

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

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.

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, including at least one item from each of the categories of FDA approved contraceptive methods (as described on the Prescription Drug List).

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 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 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 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. This exclusion does not apply to Approved Clinical Trials.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent the prescription is paid for by the local, state or federal government (for example, an Insured Person enrolled in Medicare), except as otherwise provided by law.
7. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which a claim has been paid under any workers' compensation law or other similar laws.
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. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
13. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.
14. 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.)
15. 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.
16. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate. This exclusion does not apply to special dietary treatment for phenylketonuria.
17. 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.

18. 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.
19. 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. Please see Right to Request an Exclusion Exception for additional information.
20. A Prescription Drug Product with either:
 - An approved biosimilar.
 - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.For the purpose of this exclusion a “biosimilar” is a biological Prescription Drug Product approved based on 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.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.
21. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
22. Durable medical equipment and related supplies for which benefits are provided in the medical expense benefits portion of this Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered. This exclusion does not apply to supplies as referenced in the definition of a Prescription Drug Product.
23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
25. 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.
26. 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 located on the Insured’s ID card. 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 located on the Insured’s ID card. 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

the number located on the Insured's ID card 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.

Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for the Insured Person.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to an Insured Person's health or ability to regain maximum function.

If a request for an exception is approved by the Company, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information, please visit [www.uhcprovider.com] under the following path: [*Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act \$0 Cost-Share Preventive Medications Exemption Requests (Commercial Members)*].

Section 23: Assistance and Evacuation Benefits

An Insured Person under this insurance plan is eligible for Assistance and Evacuation Benefits in addition to the underlying plan coverage. The requirements to receive these benefits are as follows:

International Students, insured spouse, and insured minor child(ren) are eligible to receive Assistance and Evacuation Benefits worldwide, except in their Home Country.

Domestic Students, insured spouse, and insured minor child(ren) are eligible for Assistance and Evacuation Benefits when 100 miles or more away from their campus address or 100 miles or more away from their permanent home address or while participating in a study abroad program.

DEFINITIONS

The following definitions apply to the Assistance and Evacuation Benefits described further below.

"Emergency Medical Event" means an event wherein an Insured Person's medical condition and situation are such that, in the opinion of the Company's affiliate or authorized vendor and the Insured Person's treating physician, the Insured Person requires urgent medical attention without which there would be a significant risk of death, or serious impairment and adequate medical treatment is not available at the Insured Person's initial medical facility.

"Home Country" means, with respect to an Insured Person, the country or territory as shown on the Insured Person's passport or the country or territory of which the Insured Person is a permanent resident.

"Host Country" means, with respect to an Insured Person, the country or territory the Insured Person is visiting or in which the Insured Person is living, which is not the Insured Person's Home Country.

"Physician Advisors" mean physicians retained by the Company's affiliate or authorized vendor for provision of consultative and advisory services to the Company's affiliate or authorized vendor, including the review and analysis of the medical care received by Insured Persons.

An Insured Person must notify the Company's affiliate or authorized vendor to obtain benefits for Medical Evacuation and Repatriation. If the Insured Person doesn't notify the Company's affiliate or authorized vendor, the Insured Person will be responsible for paying all charges and no benefits will be paid.

MEDICAL EVACUATION AND REPATRIATION BENEFITS

Emergency Medical Evacuation: If an Insured Person suffers a Sickness or Injury, experiences an Emergency Medical Event and adequate medical facilities are not available locally in the opinion of the *Medical Director* of the Company's affiliate or authorized vendor, the Company's affiliate or authorized vendor will provide an emergency medical evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. The Company will pay costs for arranging and providing for transportation and related medical services

(including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the emergency medical evacuation.

Dispatch of Doctors/Specialists: If an Insured Person experiences an Emergency Medical Event and the Company's affiliate or authorized vendor determines that an Insured Person cannot be adequately assessed by telephone for possible medical evacuation from the initial medical facility or that the Insured Person cannot be moved and local treatment is unavailable, the Company's affiliate or authorized vendor will arrange to send an appropriate medical practitioner to the Insured Person's location when it deems it appropriate for medical management of a case. The Company will pay costs for transportation and expenses associated with dispatching a medical practitioner to an Insured Person's location, not including the costs of the medical practitioner's service.

Medical Repatriation: After an Insured Person receives initial treatment and stabilization for a Sickness or Injury, if the attending physician and the *Medical Director* of the Company's affiliate or authorized vendor determine that it is medically necessary, the Company's affiliate or authorized vendor will transport an Insured Person back to the Insured Person's permanent place of residence for further medical treatment or to recover. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Transportation after Stabilization: If Medical Repatriation is not required following stabilization of the Insured Person's condition and discharge from the hospital, the Company's affiliate or authorized vendor will coordinate transportation to the Insured Person's point of origin, Home Country, or Host Country. The Company will pay costs for economy transportation (or upgraded transportation to match an Insured Person's originally booked travel arrangements) to the Insured Person's original point of origin, Home Country or Host Country.

Transportation to Join a Hospitalized Insured Person: If an Insured Person who is travelling alone is or will be hospitalized for more than three (3) days due to a Sickness or Injury, the Company's affiliate or authorized vendor will coordinate round-trip airfare for a person of the Insured Person's choice to join the Insured Person. The Company will pay costs for economy class round-trip airfare for a person to join the Insured Person.

Return of Minor Children: If an Insured Person's minor child(ren) age 18 or under are present but left unattended as a result of the Insured Person's Injury or Sickness, the Company's affiliate or authorized vendor will coordinate airfare to send them back to the Insured Person's Home Country. The Company's affiliate or authorized vendor will also arrange for the services, transportation expenses, and accommodations of a non-medical escort, if required as determined by the Company's affiliate or authorized vendor. The Company will pay costs for economy class one-way airfare for the minor children (or upgraded transportation to match the Insured Person's originally booked travel arrangement) and, if required, the cost of the services, transportation expenses, and accommodations of a non-medical escort to accompany the minor children back to the Insured Person's Home Country.

Repatriation of Mortal Remains: In the event of an Insured Person's death, the Company's affiliate or authorized vendor will assist in obtaining the necessary clearances for the Insured Person's cremation or the return of the Insured Person's mortal remains. The Company's affiliate or authorized vendor will coordinate the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence, as it obtains the number of certified death certificates required by the Host Country and Home Country to release and receive the remains. The Company will pay costs for the certified death certificates required by the Home Country or Host Country to release the remains and expenses of the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence.

CONDITIONS AND LIMITATIONS

Assistance and Evacuation Benefits shall only be provided to an Insured Person after the Company's affiliate or authorized vendor receives the request (in writing or via phone) from the Insured Person or an authorized representative of the Insured Person of the need for the requested Assistance and Evacuation Benefits. In all cases, the requested Assistance and Evacuation Benefits services and payments must be arranged, authorized, verified and approved in advance by the Company's affiliate or authorized vendor.

With respect to any evacuation requested by an Insured Person, the Company's affiliate or authorized vendor reserves the right to determine, at its sole discretion, the need for and the feasibility of an evacuation and the means, method, timing, and destination of such evacuation, and may consult with relevant third-parties, including as applicable, Physician Advisors and treating physicians as needed to make its determination.

In the event an Insured Person is incapacitated or deceased, his/her designated or legal representative shall have the right to act for and on behalf of the Insured Person.

The following Exclusions and Limitations apply to the Assistance and Evacuation Benefits.

In no event shall the Company be responsible for providing Assistance and Evacuation Benefits to an Insured Person in a situation arising from or in connection with any of the following:

1. Travel costs that were neither arranged nor approved in advance by the Company's affiliate or authorized vendor.
2. Taking part in military or police service operations.
3. Insured Person's failure to properly procure or maintain immigration, work, residence or similar type visas, permits or documents.
4. The actual or threatened use or release of any nuclear, chemical or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of contributory cause.
5. Any evacuation or repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
7. Medical Evacuations directly or indirectly related to a natural disaster.
8. Subsequent Medical Evacuations for the same or related Sickness, Injury or Emergency Medical Event regardless of location.

Additional Assistance Services

The following assistance services will be available to an Insured Person in addition to the Assistance and Evacuation Benefits.

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: Upon an Insured Person's request, the Company's affiliate or authorized vendor will provide referrals to physicians, hospitals, dentists, and dental clinics in the area the Insured Person is traveling in order to assist the Insured Person in locating appropriate treatment and quality care.

Monitoring of Treatment: As and to the extent permissible, the Company's affiliate or authorized vendor will continually monitor the Insured Person's medical condition. Third-party medical providers may offer consultative and advisory services to the Company's affiliate or authorized vendor in relation to the Insured Person's medical condition, including review and analysis of the quality of medical care received by the Insured Person.

Facilitation of Hospital Admittance Payments: The Company's affiliate or authorized vendor will issue a financial guarantee (or wire funds) on behalf of Company up to five thousand dollars (US\$5,000) to facilitate admittance to a foreign (non-US) medical facility.

Relay of Insurance and Medical Information: Upon an Insured Person's request and authorization, the Company's affiliate or authorized vendor will relay the Insured Person's insurance benefit information and/or medical records and information to a health care provider or treating physician, as appropriate and permissible, to help prevent delays or denials of medical care. The Company's affiliate or authorized vendor will also assist with hospital admission and discharge planning.

Medication and Vaccine Transfers: In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, the Company's affiliate or authorized vendor will coordinate the transfer of the medication or vaccine to Insured Persons upon the prescribing physician's authorization, if it is legally permissible.

Updates to Family, Employer, and Home Physician: Upon an Insured Person's approval, the Company's affiliate or authorized vendor will provide periodic case updates to appropriate individuals designated by the Insured Person in order to keep them informed.

Hotel Arrangements: The Company's affiliate or authorized vendor will assist Insured Persons with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care.

Replacement of Corrective Lenses and Medical Devices: The Company's affiliate or authorized vendor will assist with the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, an Insured Person can contact the Company's affiliate or authorized vendor to have a pre-trip destination report sent to the Insured Person. This report draws upon an intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. The global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: The Company's affiliate or authorized vendor will assist the Insured Person in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: The Company's affiliate or authorized vendor will make new reservations for airlines, hotels, and other travel services for an Insured Person in the event of a Sickness or Injury, to the extent that the Insured Person is entitled to receive Assistance and Evacuation Benefits.

Transfer of Funds: The Company's affiliate or authorized vendor will provide the Insured Person with an emergency cash advance subject to the Company's affiliate or authorized vendor first securing funds from the Insured Person (via a credit card) or his/her family.

Legal Referrals: Should an Insured Person require legal assistance, the Company's affiliate or authorized vendor will direct the Insured Person to a duly licensed attorney in or around the area where the Insured Person is located.

Language Services: The Company's affiliate or authorized vendor will provide immediate interpretation assistance to an Insured Person in a variety of languages in an emergency situation. If a requested interpretation is not available or the requested assistance is related to a non-emergency situation, the Company's affiliate or authorized vendor will provide the Insured Person with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter, will be subject to an additional fee.

Message Transmittals: Insured Persons may send and receive emergency messages toll-free, 24-hours a day, through the Company's affiliate or authorized vendor.

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

Assistance and Evacuation Services are available 24 hours a day, 7 days a week, 365 days a year.

To access services, please refer to the phone number on the back of the Insured Person's ID Card or access My Account at www.uhcsr.com/MyAccount and select My Benefits/Additional Benefits/UHC Global Emergency Services.

When calling the Emergency Response Center, the caller should be prepared to provide the following information:

- Caller's name, telephone and (if possible) fax number, and relationship to the Insured Person.
- Insured Person's name, age, sex, and ID Number as listed on the Insured Person's Medical ID card.
- Description of the Insured Person's condition.
- Name, location, and telephone number of hospital, if applicable.
- Name and telephone number of the attending physician.
- Information on where the physician can be immediately reached.

If the condition is a medical emergency, the Insured Person should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center.

All medical expenses related to hospitalization and treatment costs incurred should be submitted to the Company for consideration at the address located in the "How to File a Claim for Injury and Sickness Benefits" section of the Certificate of Coverage and are subject to all Policy benefits, provisions, limitations, and exclusions.

Schedule of Benefits

CCCS-MN-Gold Enhanced 1

2024-203096-61

METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 84.800%

Injury and Sickness Benefits

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

Deductible Preferred Provider	\$250 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	\$600 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	50% except as noted below
Out-of-Pocket Maximum Preferred Provider	\$7,500 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	\$13,700 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	\$15,000 (Per Insured Person, Per Policy Year)

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

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

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. 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. All other Covered Medical Expenses provided by an Out-of-Network Provider at a Preferred Provider facility will be paid at the Preferred Provider Benefit level.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network Provider Benefits. 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. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays.

Student Health Center Benefits: 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. Policy Exclusions and Limitations do not apply.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network 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	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Intensive Care	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Hospital Miscellaneous Expenses	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness

Inpatient	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.	80% of Allowed Amount after Deductible	50% of 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.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Registered Nurse's Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Physician's Visits	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	80% of Allowed Amount after Deductible	50% of 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.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Day Surgery Miscellaneous	80% of Allowed Amount after Deductible	50% of 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.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Physician's Visits	\$25 Copay per visit 80% of Allowed Amount not subject to Deductible	50% of Allowed Amount after Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	\$150 Copay per visit 80% of Allowed Amount not subject to Deductible	\$150 Copay per visit 80% of Allowed Amount not subject to Deductible
Diagnostic X-ray Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Radiation Therapy	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Laboratory Procedures	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Tests & Procedures	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Injections	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Chemotherapy	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit for additional information. The Insured may obtain up to 12 cycles of contraceptives at one time subject to the Copay for each cycle supplied, when applicable.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy \$25 Copay per prescription Tier 1 \$60 Copay per prescription Tier 2 \$75 Copay 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 is required to pay the same Copayment and/or Coinsurance as the Preferred Specialty Network. 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	80% of 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 80% of Allowed Amount not subject to Deductible	50% of Allowed Amount after Deductible
Dental Treatment	80% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Mental Illness Treatment	Inpatient: 80% of Allowed Amount after Deductible Outpatient office visits: \$25 Copay per visit 80% of Allowed Amount not subject to Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 80% of Allowed Amount after Deductible	Inpatient: 50% of Allowed Amount after Deductible Outpatient office visits: 50% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 50% of Allowed Amount after Deductible
Substance Use Disorder Treatment See Benefits for Alcoholism, Chemical Dependency and Drug Addiction	Inpatient: 80% of Allowed Amount after Deductible Outpatient office visits: \$25 Copay per visit 80% of Allowed Amount not subject to Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 80% of Allowed Amount after Deductible	Inpatient: 50% of Allowed Amount after Deductible Outpatient office visits: 50% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 50% of Allowed Amount after 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
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 Surgery	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Hospice Care	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Inpatient Rehabilitation Facility	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Skilled Nursing Facility	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Urgent Care Center	\$50 Copay per visit 80% of Allowed Amount not subject to Deductible	\$50 Copay per visit 50% of Allowed Amount not subject to Deductible
Hospital Outpatient Facility or Clinic	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Genetic Testing	Paid as any other Sickness	Paid as any other Sickness
Medical Foods See also Benefits for Phenylketonuria Treatment	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Ventilator Benefits See Benefits for Ventilator Dependency	Paid as any other Sickness	Paid as any other Sickness
Port-Wine Stain Elimination See Benefits for Port-Wine Stains	Paid as any other Sickness	Paid as any other Sickness
Lyme Disease See Benefits for Lyme Disease Treatment	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids See Benefits for Hearing Aids	Paid as any other Sickness	Paid as any other Sickness
Titers Benefits are allowed for titers related to the following immunizations: Polio Virus Immune status, Varicella-Zoster AB, IgG, Hepatitis B surf AB, MMR, Hep B, Hep A, Tdap, and Rubella.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Tuberculosis Screening and Testing Benefits are limited to TB Screening and testing not covered under the Preventive Care Services Benefit.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible

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:

Thomas J. Wilder
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.

