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2016–2017 Student Injury and Sickness Insurance Plan

Designed Especially for the International Students of



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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or visiting us at www.uhcsr.com.

Eligibility

All registered international students taking one (1) or more credit hours are required to purchase this insurance Plan, unless proof of comparable coverage is furnished. International students are automatically enrolled, and the premium will be added to their tuition bill. All international students with U.S. based employer and embassy plans are eligible to waive the plan as determined by the SHSU Student Health Services.

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

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.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 15, 2016. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 14, 2017. 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.

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

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

Extension of Benefits after Termination

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

Coverage under the policy will not apply if the coverage is replaced with a succeeding carrier providing substantially equivalent or greater benefits than those provided by this policy. For purposes of this section, the terms "Total Disability" and "Totally Disabled" mean: 1) with respect to the Insured, the complete inability of the Insured to perform all of the substantial and material duties and functions of his or her occupation and any other gainful occupation in which such person earns substantially the same compensation earned prior to disability, and 2) with respect to the Insured's covered Dependents, confinement as a bed patient in a Hospital.

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

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

Pre-Admission Notification

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

1. **PRE-ADMISSION 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. **PRE-ADMISSION 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.

Preferred Provider Information

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

"Out-of-Network" providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

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

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-800-767-0700 for information about Preferred Hospitals.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Choice Plus will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Medical Emergency Treatment

In the event of Medical Emergency and the Insured cannot reasonably reach a Preferred Provider, the Company shall provide reimbursement for the following Medical Emergency services at the Preferred Provider level of benefits until the Insured can reasonably be expected to transfer to a Preferred Provider: 1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital, including a freestanding emergency medical care facility, that is necessary to determine whether a Medical Emergency condition exists; 2) necessary Medical Emergency care services, including the treatment and stabilization of a Medical Emergency condition; and 3) services originating in a Hospital emergency facility, including a freestanding emergency medical care facility, following treatment or stabilization of a Medical Emergency condition.

Complaint Resolution

Insured Persons, Preferred Providers, Out-of-Network Providers or their representatives with questions or complaints may call the Customer Service Department at 1-800-767-0700. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

Continuity of Care; Termination of Provider Contracts

The Insured has the right to continuity of care while covered under this policy for a covered Injury or Sickness in the event of termination of a Preferred Provider's participation in the plan under the following circumstances: 1) the Insured is being treated for a Life Threatening Condition; or 2) the Insured is being treated under Special Circumstances.

"Life Threatening Condition" means a Sickness or Injury for which the likelihood of death is probably unless the course of the Injury or Sickness is interrupted. "Special Circumstances" means a condition regarding which the treating Physician or health care provider reasonably believes that discontinuing care by the treating Physician or health care provider could cause harm to the Insured. Examples of an Insured who has a special circumstance include an Insured with a disability, acute condition, or Life Threatening Condition or an Insured who is past the 24th week of pregnancy.

Benefits will continue to be paid at the negotiated Preferred Provider level of benefits if an Insured whom the Physician or provider is currently treating has Special Circumstances in accordance with the dictates of medical prudence. The Physician or provider shall identify the Special Circumstances and shall: 1) request that the Insured be permitted to continue treatment under the Physician's or providers care; and 2) agree not to seek payment from the Insured of any amount for which the Insured would not be responsible if the Physician or provider were still a Preferred Provider.

All obligations on behalf of the Company for reimbursement at the Preferred Provider level of benefits for the ongoing treatment shall terminate after 1) the 90th day after the effective date of the termination or 2) if the Insured has been diagnosed as having a terminal Sickness at the time of termination, the expiration of a nine-month period after the effective date of the termination. If the Insured is past the 24th week of pregnancy at the time of termination, the Company shall continue the Preferred Provider benefits through the delivery of the child, immediate postpartum care and the follow-up checkup within the six-week period after deliver.

NOTICE: Although services may be or have been provided to an Insured at a health care facility that is a member of the Preferred Provider network, other professional services may be or have been provided at or through the facility by Physicians and other health care practitioners who are not members of the Preferred Provider network. The Insured may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by this policy.

- You have the right to an adequate network of Preferred Providers (also known as "network providers").
 - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
 - If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network Deductible and Out-of-Pocket Maximum.

- You have the right, in most cases, to obtain estimates in advance:
 - from out-of-network providers of what they will charge for their services; and
 - from your insurer of what it will pay for the services.
- You may obtain a current directory of Preferred Providers at the following website: uhcsr.com or by calling (800) 767-0700 for assistance in finding available Preferred Providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.
- If you are treated by a provider or Hospital that is not a Preferred Provider, you may be billed for anything not paid by the Insurer.
- If the amount you owe to an out-of-network Hospital-based radiologist, anesthesiologist, pathologist, emergency department Physician, neonatologist, or an assistant surgeon is greater than \$500 (not including your Copayment, Coinsurance, and Deductible responsibilities) for services received in a network Hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website:
www.tdi.texas.gov/consumer/cpmmediation.html.

Schedule of Medical Expense Benefits

METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 81.071%

Injury and Sickness Benefits

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

Deductible Preferred Providers	\$500 (Per Insured Person, Per Policy Year)
Deductible Preferred Providers	\$1,500 (For all Insureds in a Family, Per Policy Year)
Deductible Out-of-Network	\$1,000 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network	\$3,000 (For all Insureds in a Family, Per Policy Year)
Coinsurance Preferred Providers	80% except as noted below
Coinsurance Out-of-Network	60% except as noted below
Out-of-Pocket Maximum Preferred Providers	\$6,350 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Providers	\$12,700 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network	\$12,700 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network	\$25,400 (For all Insureds in a Family, Per Policy Year)

The Preferred Providers for this plan are UnitedHealthcare Choice Plus.

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

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

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses 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 per service Deductibles.

Student Health Center Benefits (Students Only): The plan Deductible and Copay will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

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

Inpatient	Preferred Provider	Out-of-Network Provider
Room and Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care See Benefits for Maternity and Post Delivery Care	Paid as any other Sickness	Paid as any other Sickness

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

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	100% of Preferred Allowance \$30 Copay per visit	Usual and Customary Charges
Physiotherapy Limits per Policy Year as follows: 35 visits for any combination of physical therapy, occupational therapy, cardiac rehabilitation, and manipulative therapy.	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses The Copay/per visit Deductible will be waived if admitted to the Hospital.	Preferred Allowance \$150 Copay per visit	80% of Usual and Customary Charges \$150 Deductible per visit
Diagnostic X-ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Prescription Drugs	UnitedHealthcare Pharmacy (UHCP) \$20 Copay per prescription for Tier 1 \$40 Copay per prescription for Tier 2 \$60 Copay per prescription for Tier 3 up to a 31 day supply per prescription Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.	Usual and Customary Charges

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	Preferred Allowance	80% of Usual and Customary Charges
Durable Medical Equipment See also Benefits for Prosthetic and Orthotic Devices and Services	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees	100% of Preferred Allowance \$50 Copay per visit	Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Preferred Allowance	80% of Usual and Customary Charges
Mental Illness Treatment	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment	Paid as any other Sickness	Paid as any other Sickness
Maternity See Benefits for Maternity and Post Delivery Care	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	No Benefits	No Benefits
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 Preferred Allowance	Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes Treatment	Paid as any other Sickness	Paid as any other Sickness
Home Health Care 60 visits maximum Per Policy Year	Preferred Allowance	Usual and Customary Charges
Hospice Care	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility 25 days maximum Per Policy Year	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	100% of Preferred Allowance \$50 Copay per visit	Usual and Customary Charges
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials See Benefits for Routine Patient Care Costs for Clinical Trials	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider	Out-of-Network Provider
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids	Preferred Allowance	Usual and Customary Charges

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

Benefits are available for Prescription Drugs at an out-of-network pharmacy as specified in the policy Schedule of Benefits subject to all terms of the policy.

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change no more than one time per Policy Year. If you are actively taking a Prescription Drug Product, we will notify you electronically, or in writing, upon your request, at least sixty days prior to any deletions, other than generic substitutions. Please access www.uhcsr.com or call 1-855-828-7716 for the most up-to-date tier status.

\$20 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

\$40 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

\$60 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Mail order Prescription Drugs are available at 2.5 times the retail Copay up to a 90 day supply.

Specialty Prescription Drugs – if you require Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Pharmacy, benefits will be provided under the Out-of-Network Prescription Drug benefit.

Designated Pharmacies – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Pharmacy, benefits will be provided under the Out-of-Network Prescription Drug benefit.

Please present your ID card to the network pharmacy when the prescription is filled.

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com and log in to your online account or call 1-855-828-7716.

When prescriptions are filled at pharmacies outside the network, the Insured must pay for the prescriptions out-of-pocket and submit the receipts for reimbursement to UnitedHealthcare **StudentResources**, P.O. Box 809025, Dallas, TX 75380-9025. See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.

Additional Exclusions:

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made on the policy Effective Date, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

Definitions:

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

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

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

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

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

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

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

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

Urgent Requests

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

External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-800-767-0700. The *Independent Review Organization* (IRO) will notify the Insured Person of the determination within 72 hours.

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-800-767-0700 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

Medical Expense Benefits – Injury and Sickness

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

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

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

Inpatient

1. **Room and Board Expense.**
Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.
2. **Intensive Care.**
If provided in the Schedule of Benefits.
3. **Hospital Miscellaneous Expenses.**
When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

Benefits will be paid for services and supplies such as:
 - The cost of the operating room.
 - Laboratory tests.
 - X-ray examinations.
 - Anesthesia.
 - Drugs (excluding take home drugs) or medicines.
 - Therapeutic services.
 - Supplies.
4. **Routine Newborn Care.**
See Benefits for Maternity and Post Delivery Care.
5. **Surgery (Inpatient).**
Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**
Assistant Surgeon fees in connection with Inpatient surgery.
7. **Anesthetist Services.**
Professional services administered in connection with Inpatient surgery.
8. **Registered Nurse's Services.**
Registered Nurse's services which are all of the following:
 - Received when confined as an Inpatient.
 - Ordered by a licensed Physician.
 - A Medical Necessity.

General nursing care provided by the Hospital or Skilled Nursing Facility is not covered under this benefit.
9. **Physician's Visits (Inpatient).**
Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.
10. **Pre-admission Testing.**
Benefits are limited to routine tests such as:
 - Complete blood count.
 - Urinalysis.
 - Chest X-rays.

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

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

Outpatient

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

Physician's Visits for preventive care are provided as specified under Preventive Care Services.
16. **Physiotherapy (Outpatient).**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
 - Physical therapy.
 - Occupational therapy.
 - Cardiac rehabilitation therapy.
 - Manipulative treatment.
 - Speech therapy.

17. **Medical Emergency Expenses (Outpatient).**

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

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

18. **Diagnostic X-ray Services (Outpatient).**

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

19. **Radiation Therapy (Outpatient).**

See Schedule of Benefits.

20. **Laboratory Procedures (Outpatient).**

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

21. **Tests and Procedures (Outpatient).**

Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:

- Physician's Visits.
- Physiotherapy.
- X-rays.
- Laboratory Procedures.

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

- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.

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

22. **Injections (Outpatient).**

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

23. **Chemotherapy (Outpatient).**

See Schedule of Benefits.

24. **Prescription Drugs (Outpatient).**

See Schedule of Benefits.

Other

25. **Ambulance Services.**

See Schedule of Benefits.

26. **Durable Medical Equipment.**

Durable medical equipment must be all of the following:

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

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

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

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

See also Benefits for Prosthetic and Orthotic Devices and Services.

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.

Benefits will not be denied for treatment of a covered dental procedure for an Insured who is unable to undergo the treatment in an office setting or receive local anesthetic due to a documented physical, mental, or medical reason when determined by the Insured's Physician or dentist providing the treatment.

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, psychiatric day treatment facility or residential treatment center for children and adolescents.
- On an outpatient basis including intensive outpatient treatment.

30. Substance Use Disorder Treatment.

Benefits will be paid for services received:

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

31. Maternity.

Same as any other Sickness. See Benefits for Maternity and Post Delivery Care.

32. Complications of Pregnancy.

Same as any other Sickness.

33. Preventive Care Services.

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

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

34. **Reconstructive Breast Surgery Following Mastectomy.**
In connection with a covered mastectomy. See Benefits for Reconstructive Breast Surgery Following Mastectomy.
35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes Treatment.
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. **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.
39. **Urgent Care Center.**
Benefits are limited to:
- The facility or clinic fee billed by the Urgent Care Center.
- All other services rendered during the visit will be paid as specified in the Schedule of Benefits.
40. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- The facility or clinic fee billed by the Hospital.
- All other services rendered during the visit will be paid as specified in the Schedule of Benefits.
41. **Approved Clinical Trials.**
See Benefits for Routine Patient Care Cost for Clinical Trials.
42. **Transplantation Services.**
Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.
- Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under this policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this policy to be primary.
- No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.

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

43. Hearing Aids.

Hearing aids when required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. If more than one type of hearing aid can meet the Insured's functional needs, benefits are available only for the hearing aid that meets the minimum specifications for the Insured's needs. Benefits are limited to one hearing aid per hearing impaired ear every 36 months.

Mandated Benefits

Benefits for Telemedicine / Telehealth Services

Benefits will be paid for services provided through telemedicine and telehealth on the same basis as services provided through a face-to-face consultation. "Telemedicine" means a health care service initiated by a Physician or provided by a health professional acting under Physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunication technology, other than by telephone or facsimile, including:

- 1) Compressed digital interactive video, audio, or data transmission;
- 2) Clinical data transmission using computer imaging by way of still image capture and store and forward; and
- 3) Other technology that facilitates access to health care services or medical specialty expertise.

"Telehealth" means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including: Compressed digital interactive video, audio or data transmission, clinical data transmission using computer imaging by way of still-image capture and store and forward, and other technology that facilitates access to health care services or medical specialty expertise.

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

Benefits Following a Brain Injury

Benefits will be paid the same as any other Injury for Medically Necessary services as a result of and related to a brain injury to facilitate the recovery and progressive rehabilitation of survivors of acquired brain injuries to the extent possible to their pre-injury condition. Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Exclusions provided in the policy do not include limitations or exclusions of therapies listed and defined below. The following therapies must be provided for the coverage of an Acquired Brain Injury.

- 1) Cognitive rehabilitation therapy- Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the Insured's brain-behavioral deficits.
- 2) Cognitive communication therapy- Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
- 3) Neurocognitive therapy- Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- 4) Neurocognitive rehabilitation- Services designed to assist cognitively impaired Insureds to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- 5) Neurobehavioral testing- An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the Insured, family, or others.
- 6) Neurobehavioral treatment- Interventions that focus on behavior and the variables that control behavior.

- 7) Neurophysiological testing- An evaluation of the functions of the nervous system.
- 8) Neurophysiological treatment- Interventions that focus on the functions of the nervous system.
- 9) Neuropsychological testing- The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship normal and abnormal central nervous system functioning.
- 10) Neuropsychological treatment- Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- 11) Outpatient day treatment services- Structured services provided to address functional deficits in behavior and/or cognition delivered in settings that include transitional residential, community integration, or non-residential services.
- 12) Psychophysiological testing- An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- 13) Psychophysiological treatment- Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- 14) Neurofeedback therapy- Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- 15) Remediation- The process(es) of restoring or improving a specific function.
- 16) Post-acute transition services- Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- 17) Community reintegration services, including outpatient day treatment services- Services that facilitate the continuum of care as an affected individual transitions into the community.
- 18) Post-acute care treatment services- Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Benefits for post-acute care treatment services shall not be included in any policy maximum lifetime limit on the number of days of acute care treatment. Benefits for post-acute care treatment include reasonable expenses related to the periodic reevaluation of the care of the Insured who:

- 1) Has incurred an Acquired Brain Injury;
- 2) Has been unresponsive to treatment; and
- 3) Becomes responsive to treatment at a later date.

A determination of whether expenses are reasonable for the periodic reevaluation may include consideration of factors including:

- 1) Cost;
- 2) The time that has expired since the previous evaluation;
- 3) Any difference in the expertise of the Physician performing the evaluation;
- 4) Changes in technology; and
- 5) Advances in medicine.

Treatment for an Acquired Brain Injury may be provided at a facility at which appropriate services may be provided, including:

- 1) A Hospital, including an acute and a post-acute rehabilitation hospital; and
- 2) An assisted living facility.

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

Benefits for Temporomandibular and Craniomandibular Joint Dysfunction

Benefits will be paid the same as any other Sickness or Injury for Medically Necessary diagnostic and/or surgical treatment of conditions affecting the temporomandibular joint, including the jaw or the craniomandibular joint, as a result of an accident, trauma, congenital defect, developmental defect or a pathology.

No benefits will be paid for other dental services that are not otherwise shown in the Schedule of Benefits.

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

Benefits for Detection of Prostate Cancer

Benefits will be paid the same as any other Sickness for an annual diagnostic examination for the detection of prostate cancer, including both:

- 1) A physical examination for the detection of prostate cancer; and
- 2) A prostate-specific antigen test used for the detection of prostate cancer for each Insured who is: a) at least 50 years of age and asymptomatic; or b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

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

Benefits for Colorectal Cancer Screening

Benefits will be paid the same as any other Sickness for a medically recognized screening examination for the detection of colorectal cancer for an Insured age 50 years of age or older and at normal risk for developing colon cancer. Benefits include the Insured's choice of:

- 1) A fecal occult blood test, including stool DNA test, performed annually and a flexible sigmoidoscopy performed every five years.
- 2) A colonoscopy, including a computer tomography colonography, performed every 10 years.
- 3) One double contrast barium enema every five years.

For an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests are recommended by the treating physician.

An individual is at high risk for colorectal cancer if the individual has a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; A prior occurrence of a chronic digestive disease conditions such as inflammatory bowel disease, Crohn's disease or ulcerative colitis; or other predisposing factors.

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

Benefits for Mammography

Benefits will be paid the same as any other Sickness for an annual screening mammography for Insureds 35 years and older or more often if recommended by the Physician.

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

Benefits for Mastectomy

Benefits will be paid the same as any other Sickness for a mastectomy including a minimum of 48 hours of inpatient care following a covered mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer.

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

Benefits for Reconstructive Breast Surgery Following Mastectomy

Benefits will be paid as specified below for the reconstruction of the breast on which the mastectomy has been performed. Benefits will also be paid for surgery and reconstruction of the other breast to achieve a symmetrical appearance. Benefits will include prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy, in consultation with the attending Physician and the patient. Benefits shall be subject to the same Deductible, Copayment, Coinsurance and other provisions of the policy as for any other Sickness but shall not be subject to other dollar limitations of the policy except for any policy Maximum Benefit.

Benefits for Diabetes Treatment

Benefits will be paid the same as any other Sickness for medication, Equipment, Supplies, appliances and Self-management Training that are Medically Necessary for the treatment of Type I, Type II and gestational diabetes.

"Diabetes equipment" means:

- 1) Blood glucose monitors, including noninvasive monitors, and monitors designed to be used by blind individuals.
- 2) Insulin pumps, both external and implantable, and associated appurtenances.
- 3) Insulin infusion devices.
- 4) Podiatric appliances for the prevention of complications associated with diabetes.
- 5) Biohazard disposal containers.

"Diabetes supplies" means:

- 1) Test strips for blood glucose monitors.
- 2) Visual reading and urine test strips.
- 3) Lancets and lancet devices.
- 4) Insulin and insulin analogs.
- 5) Injection aids.
- 6) Syringes.
- 7) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels.
- 8) Glucagon emergency kits.
- 9) Batteries.
- 10) Skin preparation items.
- 11) Adhesive supplies.
- 12) Infusion sets.
- 13) Insulin cartridges.
- 14) Durable and disposable devices to assist in the injection of insulin.
- 15) Other required disposable supplies.
- 16) Tablets for glucose tests, ketones and protein.

Diabetes self-management training must be provided by a Physician or upon written order of a Physician as specified below. Self-management training includes:

- 1) Training provided to a qualified Insured after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies.
- 2) Additional training authorized on the diagnosis of a Physician of a significant change in the qualified Insured's symptoms or condition that requires changes in the qualified Insured's self-management regime.
- 3) Periodic or episodic continuing education training when prescribed by a Physician as warranted by the development of new techniques and treatments for diabetes.

If the diabetes self-management training is provided on the written order of a Physician, the training must also include:

- 1) A diabetes self-management training program recognized by the American Diabetes Association;
- 2) Diabetes self-management training provided by a multidisciplinary team:
 - a. The nonphysician members of which are coordinated by either:
 - i. A diabetes educator who is certified by the National Certification Board for Diabetes Educators;
 - ii. An individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;
 - b. That consists of at least a licensed dietitian and a Registered Nurse and may include a pharmacist and a social worker; and
 - c. Each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;
- 3) Diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or
- 4) Diabetes self-management training that provides one or more of the following components:
 - a. A nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;
 - b. A pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

- c. A component provided by a Physician assistant or registered nurse, for which the Physician assistant or registered nurse shall be paid, except that the Physician assistant or Registered Nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or
- d. A component provided by a Physician.

An individual may not provide a component of diabetes self-management training specified above unless: the subject matter of the component is within the scope of the individual's practice; and, the individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health.

All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the Physician or practitioner who issues the written order for the supplies or equipment.

Diabetes supplies includes repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

In addition to the above benefits, on the approval of the United States Food and Drug Administration of new or improved diabetes equipment or diabetes supplies, including improved insulin or other Prescription Drugs, benefits will be provided for such new or improved equipment, supplies and medicine if Medically Necessary and appropriate as determined by a Physician.

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

Benefits for Off-Label Drug Use

Benefits will be provided under the Prescription Drug Benefit for any drug prescribed to treat an Insured for a covered chronic, disabling, or life-threatening Sickness if the drug: (1) has been approved by the Food and Drug Administration for at least one indication; and (2) is recognized for treatment of the indication for which the drug is prescribed in: (A) a prescription drug reference compendium approved by the commissioner for the purpose of this article; or (B) substantially accepted peer-reviewed medical literature.

Benefits shall include coverage of Medically Necessary services associated with the administration of the drug. A drug use that is covered under this section may not be denied based on a "Medical Necessity" requirement except for reasons that are unrelated to the legal status of the drug use. This section does not require coverage for: (1) experimental drugs not otherwise approved for any indication by the Food and Drug Administration; or (2) any disease or condition that is excluded from coverage under the plan. Benefits are not provided for a drug the Food and Drug Administration has determined to be contraindicated for treatment of the current indication.

"Contraindication" means the potential for, or the occurrence of, an undesirable alteration of the therapeutic effect of a prescribed drug prescription because of the presence, in the patient for whom it is prescribed, of a disease condition, or the potential for, or the occurrence of, a clinically significant adverse effect of the drug on the patient's disease condition.

"Indication" means any symptom, cause, or occurrence in a Sickness that points out the cause, diagnosis, course of treatment, or prognosis of the Sickness.

"Peer-reviewed medical literature" means published scientific studies in any peer-reviewed national professional journal.

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

Benefits for Maternity and Post-Delivery Care

Benefits will be paid the same as any other Sickness for the Insured Mother and Newborn Infant for Maternity and Post-Delivery Care. Benefits will be provided for inpatient stay following birth for a minimum of:

- 1) 48 hours following an uncomplicated vaginal delivery.
- 2) 96 hours following an uncomplicated delivery by caesarean section.

Benefits will be provided for timely post-delivery care. That care may be provided to the Insured and Newborn Infant by a Physician, Registered Nurse, or other appropriate licensed health care provider and may be provided at either:

- 1) The Insured's home, a health care provider's office, or a health care facility.
- 2) Another location determined to be appropriate under rules adopted by the commissioner.

The benefits must allow the Insured the option to have the care provided in the Insured's home.

"Post-delivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

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

Benefits for Complications of Pregnancy

Benefits will be paid the same as any other Sickness for Complications of Pregnancy.

"Complications of Pregnancy" means: 1) conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

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

Benefits for Osteoporosis

Benefits will be paid the same as any other Sickness for a "Qualified Enrollee" for medically accepted bone mass measurement to detect low bone mass and to determine the Insured's risk of osteoporosis and fractures associated with osteoporosis.

"Qualified enrollee" means an Insured who is:

- 1) A postmenopausal woman who is not receiving estrogen replacement therapy.
- 2) An individual with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures.
- 3) An individual who is receiving long-term glucocorticoid therapy, or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

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

Benefits for Phenylketonuria or other Heritable Disease

Benefits will be provided under the Prescription Drug Benefit for the formulas necessary for the treatment of Phenylketonuria or a Heritable Disease prescribed by or under the direction of a Physician.

"Phenylketonuria" means an inherited condition that, if not treated, may cause severe mental retardation "Heritable disease" means an inherited disease that may result in mental or physical retardation or death.

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

Benefits for Amino Acid-Based Elemental Formulas

Benefits will be paid under the Prescription Drug benefit for amino acid-based elemental formula for the treatment of an Insured who is diagnosed with any of the following diseases or disorders:

- 1) Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
- 2) Severe food protein-induced enterocolitis syndrome.
- 3) Eosinophilic disorder, as evidenced by results from a biopsy.
- 4) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

Benefits will include coverage of any Medically Necessary services associated with the administration of the formula.

The treating Physician must issue a written order stating the amino acid-based elemental formula is Medically Necessary for the treatment of an Insured diagnosed with any of the diseases or disorders mentioned above.

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

Benefits for Prescription Contraceptive Drugs or Devices

Benefits will be provided for a prescription contraceptive drug or device approved by the United States Food and Drug Administration and an Outpatient Contraceptive Service. Outpatient Contraceptive Service means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

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

This benefit does not restrict benefits otherwise provided under Preventative Care Services.

Benefits for the Treatment of Craniofacial Abnormalities

Benefits will be payable for Usual and Customary Charges for an Insured who is younger than 18 years of age for reconstructive surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits are subject to the policy Deductible, and any Coinsurance or Copayment requirements of the policy.

Benefits for the Detection of Human Papillomavirus, Ovarian Cancer and Cervical Cancer

Benefits will be paid the same as any other Sickness for the early detection of ovarian cancer and cervical cancer for women 18 years of age or older. Coverage includes a CA 125 blood test and a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Screening tests required under this section must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists, or another similar national organization of medical professionals recognized by the commissioner.

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

Benefits for Prosthetic and Orthotic Devices and Services

Benefits will be paid based on the Medicare allowance for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices as specified below:

- 1) Benefits will equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. sections 1395K, 1395L, 1395M and CFR 410.100, 414.202, 414.210, and 414.228 as applicable.
- 2) Benefits will include repair and replacement of a prosthetic or orthotic device unless the repair or replacement is necessitated by misuse or loss by the Insured.
- 3) Benefits are limited to the most appropriate model of device that adequately meets the medical needs of the Insured as determined by the treating Physician or podiatrist and prosthetist or orthotist.

“Prosthetic Device” means an artificial device designed to replace, wholly or partly, an arm or leg.

“Orthotic Device” means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, but shall not be subject to any policy dollar limits but shall be subject to any other provisions of the policy.

Benefits for Routine Patient Care Costs for Clinical Trials

Benefits will be paid the same as any other Sickness for Routine Patient Care Costs to an Insured in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening Sickness and is approved by:

- 1) The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- 2) The National Institutes of Health;
- 3) The United States Food and Drug Administration;
- 4) The United States Department of Defense;
- 5) The United States Department of Veterans Affairs; or
- 6) An institutional review board of an institution in Texas which has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

“Routine Patient Care Costs” means the costs of any Medically Necessary health care service for which benefits are provided without regard to whether the Insured is participating in a clinical trial. Routine Patient Care Costs does not include:

- 1) The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- 2) The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
- 3) The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- 4) A cost associated with managing a clinical trial; or
- 5) The cost of a health care service that is specifically excluded from coverage under the plan.

Benefits will not be paid for the cost of routine patient care provided through the research institution conducting the clinical trial for the cost unless the research institution, and each health care professional providing the routine patient care through the research institution, agrees to accept reimbursement at the rates established under the plan.

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

Benefits for Orally Administered Anticancer Medications

Benefits will be paid for prescribed, orally administered anticancer medication prescribed for cancer treatment used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications.

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

Benefits for Treatment of Speech and Hearing Disorders

Benefits will be paid the same as for any other Sickness for the necessary care and treatment of loss or impairment of speech or hearing.

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

Benefits for Early Detection Test for Cardiovascular Disease

Benefits will be paid the same as any other Sickness for early detection test for atherosclerosis and abnormal artery structure and function. Benefits will be paid for one of the following screening tests every five years when performed by a laboratory certified by a recognized national organization:

- 1) Computed tomography (CT) scanning measuring coronary artery calcifications.
- 2) Ultrasonography measuring carotid intima-media thickness and plaque.

Benefits are provided only for an Insured who is:

- 1) A male older than 45 years of age and younger than 76 years of age.
- 2) A female older than 55 years of age and younger than 76 years of age.
- 3) Diabetic
- 4) Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm which is intermediate or higher.

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

Benefits for Childhood Immunizations

Benefits will be provided for childhood immunizations, following the American Pediatric Association recommendations, for Dependent children from birth through the sixth birthday.

Immunizations against diphtheria, haemophilus influenzae type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunizations that are required by law for the child shall be covered.

These benefits will not be subject to any Coinsurance, Deductible, or Copayment provisions of the policy, but will be subject to other provisions of the policy.

Benefits for Screening for Hearing Loss

Benefits will be paid the same as any other Sickness for a screening test for hearing loss for Dependent children from birth to the date the child is 30 days old and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

These benefits will not be subject to the Deductible but will be subject to any Coinsurance, Copayment, or any other provisions of the policy.

Autism and Craniofacial Endorsement

Autism Spectrum Disorder

Benefits are provided for generally recognized services, including but not limited to, evaluation and assessment for autism, applied behavioral analysis, and Habilitative Services for the treatment of autism.

Any benefit maximum listed in the Schedule of Benefits is hereby waived.

The Company may request a treatment plan from the Physician recommending treatment.

Craniofacial Abnormalities

1. Any age limitation referenced in the Benefits for Treatment of Craniofacial Abnormalities is hereby waived.

In all other respects, the Policy and Certificate provisions remain the same.

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

ADOPTED CHILD means a child whom the Insured Person is party to a suit in which the Insured Person seeks to adopt. Coverage is available under the policy for an adopted child the same as any other Newborn Infant or Dependent.

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

COMPLICATION OF PREGNANCY means: 1) conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

DEPENDENT means the legal spouse of the Named Insured and their dependent children, including any adopted child; any child in placement for adoption; any child for which suit is filed for adoption; any child for which the Named Insured is under court order to provide medical coverage; any natural born or adopted child of the spouse of the Named Insured; and, any dependent grandchild of the Named Insured. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

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

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

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

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

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

EMERGENCY SERVICES means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

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

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

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

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

INJURY means bodily injury which is all of the following:

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

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

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

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, 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 bona fide Emergency Services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placement of the Insured's health in serious jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any body organ or part.
4. Serious disfigurement.
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

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

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

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

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

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

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

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

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

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

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family. The immediate family member limitation will not prohibit the selection of a dentist of the of the Insured's choice to provide a dental care service covered under the policy provided the dentist is licensed in Texas to provide the service.

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

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

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

PRESCRIPTION DRUGS mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

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

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

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

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

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

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

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

Exclusions and Limitations

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

1. Acne.
2. Acupuncture.
3. Biofeedback.
4. Circumcision.
5. Cosmetic procedures, except reconstructive procedures to:
 - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
6. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
7. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Elective abortion.
10. Foot care for the following:
 - Flat foot conditions.
 - Supportive devices for the foot, except as specifically provided in Benefits for Prosthetic and Orthotic Devices and Services.
 - Subluxations of the foot.
 - Fallen arches.
 - Weak feet.
 - Chronic foot strain.
 - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
11. Hirsutism. Alopecia.
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
13. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except for a Medical Emergency when traveling for academic study abroad programs, business, or pleasure.
14. Injury sustained while:
 - Participating in any intercollegiate, or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
15. Investigational services.
16. Lipectomy.
17. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy and in the Benefits for Diabetes.
 - Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.

- Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
 - Growth hormones.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
18. Reproductive/Infertility services including but not limited to the following:
- Procreative counseling.
 - Genetic counseling and genetic testing.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Female sterilization procedures, except as specifically provided in the policy.
 - Vasectomy.
 - Reversal of sterilization procedures.
 - Sexual reassignment surgery.
19. 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.
20. 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.
21. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
22. 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.
23. Sleep disorders.
24. Supplies, except as specifically provided in the policy.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
27. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
28. Weight management. Weight reduction. Nutrition programs. Treatment for obesity Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.

Academic Emergency Services

These services are not provided or underwritten by: UnitedHealthcare Insurance Company.

To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans has included Academic Emergency Services (AES) benefits in your student health plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small.

The following services and benefits are available to you 24 hours a day, 7 days a week:

Medical Assistance: Pre-travel information; physician referrals; medical monitoring to ensure adequate care; 24/7 Nurse Help Line; prescription assistance or medicine dispatch.

Emergency Medical Evacuation and Repatriation: Unlimited benefit for evacuation from inadequate facility to a higher level of care facility, repatriation home for continued care if medically necessary, or recovery and repatriation of deceased remains.

Accidental Death and Dismemberment: \$25,000 benefit

Emergency Family Assistance: Benefits for visit of a family member or friend if hospitalized for 3 or more days, return of children if left unattended, bereavement reunion, emergency return home in the event a participant's family member suffers life threatening illness or death and return of participant's personal belongings in the event of evacuation or death.

Travel, Legal and Security Assistance: Pre-travel destination information or security advice; assistance locating lost luggage; passport replacement assistance; emergency travel arrangements; translation assistance; interpreter referral; legal consultation and referral; emergency message forwarding.

Preparing for your time away from home is easy; simply visit the Academic Emergency Services portal:

aes.myahpcare.com

To obtain additional pre-travel information or advice, or in the event of a medical, travel or security crisis, call Academic Emergency Services immediately.

(855) 873-3555 call toll free from the US
+ 1 (410) 453-6354 call collect from anywhere
Email: assistance@ahpcare.com

This provides you with a brief outline of the services available to you. Terms, conditions, limitations and exclusions apply. All services must be arranged and paid for through the AES service provider, UnitedHealthcare Global. There is no claim process for reimbursement of self-paid expenses unless specifically described in the service plan.

Academic Emergency Services (AES) is a global emergency services product. These services are provided by a separate and independent company from AES or Academic HealthPlans. AES provides medical, security and natural disaster evacuation services, repatriation of remains, emergency medical and travel assistance, travel information and other services for Academic HealthPlans.

Online Access to Account Information

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

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

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

ID Cards

One way we are becoming greener is to no longer automatically mail out **ID Cards**. Instead, we will send an email notification when the digital ID card is available to be downloaded from **My Account**. An Insured student may also use **My Account** to request delivery of a permanent ID card through the mail.

UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.

- Provider Search – search for In-Network participating Healthcare or Mental Health providers, call the office or facility; view a map.
- Find My Claims – view claims received within the past 60 days for both the primary insured and covered dependents; includes Provider, date of service, status, claim amount and amount paid.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to **My Account** as described above and select **UnitedHealth Allies Plan** to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number (insured's insurance company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

UnitedHealthcare **StudentResources**
P.O. Box 809025
Dallas, TX 75380-9025

Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

Insured Persons must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. Participation status can be verified by calling the Company and/or the provider. If necessary, the Company can provide assistance in referring the Insured Person to a Network Dental Provider.

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

Non-Network Benefits apply when Covered Dental Services are obtained from non-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. As a result, an Insured Person may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. In addition, when Covered Dental Services are obtained from non-Network Dental Providers, the Insured must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

Benefits are eligible for Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

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

Pre-Treatment Estimate

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

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the policy.

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

Section 2: Benefits for Pediatric Dental Services

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

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

Dental Services Deductible

Benefits for pediatric Dental Services are not subject to the policy Deductible stated in the policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Policy Year is \$500 per Insured Person.

Out-of-Pocket Maximum

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

Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	50%	50%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	50%	50%
Periodic Oral Evaluation (Checkup Exam) Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.	50%	50%
Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	50%	50%
Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50%	50%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	50%	50%
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	50%	50%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50%	50%
Endodontics (Root Canal Therapy)	50%	50%
Periodontal Surgery (Gum Surgery) Limited to 1 quadrant or site per 36 months per surgical area.	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50%	50%
Oral Surgery, including Surgical Extraction	50%	50%
Adjunctive Services		
General Services (including Dental Emergency treatment) Covered as a separate benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guards limited to 1 guard every 12 months.	50%	50%
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebased Dentures Limited to relining/rebased performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	50%	50%
Implants		
Implant Placement Limited to 1 time per 60 months.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Implant Supported Prosthetics Limited to 1 time per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	50%	50%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium Limited to 1 time per 60 months.	50%	50%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	50%	50%
MEDICALLY NECESSARY ORTHODONTICS		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.		
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	50%	50%

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. 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.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

Claim Forms

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

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

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

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

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-877-816-3596. This number is also listed on the Insured's Dental ID Card.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits

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

Non-Network Benefits

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

Policy Deductible

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

Benefit Description

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

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

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well the Insured sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

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

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

Contact Lenses - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

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

Necessary Contact Lenses - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.

- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision - Benefits are available to an Insured Person who has severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by the Company.

This benefit includes:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of \$20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• 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.
• Tint		20%	Non-Network Benefits are not available.
• Oversized Lenses		20%	Non-Network Benefits are not available.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to \$130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - 160.		100% after a Copayment of \$15.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$160 - 200.		100% after a Copayment of \$30.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - 250.		100% after a Copayment of \$50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.		60%	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Contact Lenses	Limited to a 12 month supply.		
<ul style="list-style-type: none"> Covered Contact Lens Selection 		100% after a Copayment of \$40.	50% of the billed charge.
<ul style="list-style-type: none"> Necessary Contact Lenses 		100% after a Copayment of \$40.	50% of the billed charge.
Low Vision Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Services, the Insured will be required to pay all billed charges at the time of service. The Insured may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
<ul style="list-style-type: none"> Low Vision Testing 		100% of the billed charge.	75% of the billed charge.
<ul style="list-style-type: none"> Low Vision Therapy 		100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060

Reimbursement for Low Vision Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

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

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the policy.

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

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

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's 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 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **StudentResources**, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

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

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: UnitedHealthcare **StudentResources**, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

After exhausting the Company's Internal Appeal process, the Insured Person, or the Insured Person's Authorized Representative, has the right to request an External Independent Review when the service or treatment in question:

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

Standard External Review

A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited External Review

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

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
 - a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
 - b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and
 - a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

Standard Experimental or Investigational External Review

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 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational External Review

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. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
 - a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
 - b. 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 is not initiated promptly; or
2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and
 - a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - b. The Final Adverse Determination 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 initiated promptly.

Where to Send External Review Requests

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

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

Questions Regarding Appeal Rights

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

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

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439
<http://www.tdi.texas.gov>
ConsumerProtection@tdi.texas.gov

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
800-767-0700

Plan is arranged by:
Academic HealthPlan, Inc.
P.O. Box 1605
Colleyville, TX 76034-1605
1-817-479-2100
1-855-247-2273

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

This Certificate is based on Policy # 2016-3893-4.



POLICY NUMBER: 2016-3893-4

NOTICE:

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

NOC1 - 08/30/2016

Changes have been made as a result of the Centers for Medicare & Medicaid Services' (CMS') receipt and review of the forms to ensure compliance with the market reforms of the Affordable Care Act according to current regulations.

1. Removed the following wording from exclusion #5 - Treat or correct Congenital Conditions of a Newborn Infant or an Insured Dependent under age 19."
2. Added the Autism and Craniofacial Endorsement