NOTE: Benefits and rates are subject to review by the Centers for Medicare & Medicaid Services (CMS). We reserve the right to make any changes that CMS may require.

2016–2017 Student Injury and Sickness Insurance Plan

Designed Especially for the International Students of

Missouri State University

UnitedHealthcare®

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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

International students with an F-1 or J-1 visa status (including ESL students) are required to purchase this insurance Plan.

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., July 11, 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 9, 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.

Rates	Fall 8/10/16 - 12/31/16	Spring/Summer 1/1/17 - 8/9/17	Summer 6/1/17 - 8/9/17
Student	$642	$642	$246
Spouse	$642	$642	$246
One Child	$642	$642	$246
Two or More Children	$1,284	$1,284	$492
Spouse and 2 or More Children	$1,926	$1,926	$738

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

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.

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.

Taylor Health and Wellness Center

Taylor Health and Wellness Center is a medical facility located on campus and is dedicated to providing quality, economical health care to the University community that emphasizes wellness and a balanced growth of a healthy mind, body, and spirit.

The well-qualified staff consists of doctors, nurses, technicians, pharmacists, and other medical support personnel. Each one is dedicated to the promotion, protection, and restoration of your health.

Address:
901 S. National
Springfield, MO 65897

Telephone:
(417) 836-4000

Student Health Center (SHC) Referral Required – Taylor Health and Wellness Center

OUTPATIENT SERVICES ONLY

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

A Taylor Health and Wellness Center referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. The student and Spouse must return to Taylor Health and Wellness Center for necessary follow-up care.
2. When the Taylor Health and Wellness Center is closed.
3. When service is rendered at another facility during break or vacation periods.
4. Medical care received when the student is more than 50 miles from campus.
5. Medical care obtained when a student is no longer able to use the Taylor Health and Wellness Center due to a change in student status.
6. Maternity, obstetrical and gynecological care.
7. Mental Illness treatment and Substance Use Disorder treatment.

Dependent children are not eligible to use the Taylor Health and Wellness Center and therefore are exempt from the above limitations and requirements.

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 Options PPO.

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 1-844-255-8361 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.

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 Options PPO United Behavioral Health (UBH) facilities. Call 1-844-255-8361 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 Options PPO will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Schedule of Medical Expense Benefits

Injury and Sickness Benefits
METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 81.744%

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

Deductible Preferred Providers	**$250 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network	**$500 (Per Insured Person, 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	**$6,850 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Providers	**$13,700 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$13,700 (Per Insured Person, Per Policy Year)**

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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 and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Taylor Health and Wellness 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 Expenses	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges

Inpatient	Preferred Provider	Out-of-Network Provider
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	Preferred Allowance $10 Copay per visit	Usual and Customary Charges $10 Deductible per visit Waived at Taylor Health and Wellness Center
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness, except as provided under Benefits for Chiropractic Care.	Preferred Allowance $10 Copay per visit	Usual and Customary Charges $10 Deductible per visit
Medical Emergency Expenses The Copay/per visit Deductible will be waived if admitted to the Hospital.	Preferred Allowance $100 Copay per visit	Usual and Customary Charges $100 Deductible per visit
Diagnostic X-ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures T-spot tuberculosis testing is covered at the Taylor Health and Wellness Center only. Benefits are payable at 100% with no policy Deductible.	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Prescription Drugs	**HealthSmart Rx** $25 Copay per prescription generics $50 Copay per prescription preferred brand $60 Copay per prescription non-preferred brand up to a 31 day supply per prescription Mail order Prescription Drugs through HealthSmart at 2.5 times the retail Copay up to a 90 day supply.	$50 Deductible per prescription for generic drugs $70 Deductible per prescription for brand name up to a 31 day supply per prescription **Taylor Health and Wellness Pharmacy** $15 Copay for generic ($0 Copay for generic Contraception); $30 Copay for brand name when generic is not available; $50 Copay for brand name when a generic is available up to a 30 day supply per prescription

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	Preferred Allowance	80% of Usual and Customary Charges
Durable Medical Equipment	Preferred Allowance	80% of Usual and Customary Charges
Consultant Physician Fees	Preferred Allowance $10 Copay per visit	Usual and Customary Charges $10 Deductible per visit
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Preferred Allowance	80% of Usual and Customary Charges
Mental Illness Treatment See Benefits for Chemical Dependency and Mental Illness	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment See Benefits for Chemical Dependency and Mental Illness	Paid as any other Sickness	Paid as any other Sickness
Maternity See Benefits for Maternity Expenses	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
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 Prosthetic Devices and Reconstructive Surgery	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Preferred Allowance	Usual and Customary Charges
Hospice Care	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	Preferred Allowance	Usual and Customary Charges
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials See also Benefits for Clinical Trials for Cancer Treatment	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges
Ostomy Supplies	Preferred Allowance	Usual and Customary Charges
Wigs	Preferred Allowance	Usual and Customary Charges
Non-Prescription Enteral Formulas Benefits are payable when a Physician issues a written order for treatment of malabsorption caused by a Sickness.	Paid as any other Sickness	Paid as any other Sickness

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 Expenses.

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

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

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

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

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

9. **Physician's Visits (Inpatient).**
   Non-surgical Physician services when confined as an Inpatient. 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. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, stroke, surgery, cancer, or vocal nodules.

See also Benefits for Chiropractic Care.

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. If a covered Prescription Drug is prescribed in a single dosage amount and the drug is not manufactured in such single dosage amount and requires dispensing in a combination of different manufactured dosage amounts, only one Copayment or Deductible for the dispensing of the combination of the manufactured dosages that equal the prescribed dosage for such Prescription Drug will apply. A new Copayment or Deductible will apply to each 31 day supply of the Prescription Drug.

Coverage for prescription eye drops will be provided without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing Physician authorizes such early refill and the Company is notified.

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 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.

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.**
See Benefits for Chemical Dependency and Mental Illness.

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

31. **Maternity.**
Same as any other Sickness. See Benefits for Maternity Expenses.

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

33. **Preventive Care Services.**
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

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

35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. Benefits will be provided to Insured Persons with gestational, type I or type II diabetes.

Benefits will be paid for Medically Necessary:
- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.

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

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

Benefits also include private duty nursing services provided by a Registered Nurse or licensed practical nurse only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. Private duty nursing services includes teaching and monitoring of complex care skills such as a tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care.

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

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

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

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

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

39. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

40. **Urgent Care Center.**
Benefits are limited to the facility or clinic fee billed by the Urgent Care Center.

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

41. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to the facility or clinic fee billed by the Hospital.

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

42. **Approved Clinical Trials.**
Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider

in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include:

- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

See also Benefits for Clinical Trials for Cancer Treatment.

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

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under 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.

44. **Medical Supplies.**
Medical supplies must meet all of the following criteria:

- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

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

45. **Ostomy Supplies.**
Benefits for ostomy supplies are limited to the following supplies:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

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

46. **Wigs.**
Wigs and other scalp hair prosthesis as a result of hair loss due to cancer.

Benefits are limited to the first wig following cancer treatment, not to exceed one per Policy Year.

Benefits for Treatment of Chemical Dependency and Mental Illness

Benefits will be paid the same as any other Sickness for treatment of Chemical Dependency and Mental Illness subject to the following limitations and conditions:

Chemical Dependency

Benefits will be paid for:

1. Nonresidential Treatment Programs or partial- or full-Day Program Services.
2. Residential Treatment Programs.
3. Medical or Social Setting Detoxification.

Mental Illness

Benefits will be paid for:

1. Partial or full Day Program Services and Residential Treatment Programs rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals.
2. Inpatient treatment.
3. Diagnosis or assessment of Mental Illness. Payment of benefits is not dependent upon findings.

Diagnosis or assessment of Mental Illness may be provided by any Physician regardless of any Preferred Provider Provisions that may apply to other benefits under the policy.

For the purposes of this benefit, the following terms have the meanings as defined.

"Chemical dependency" means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

"Day program services" means a structured, intensive day or evening treatment or partial hospitalization program certified by the department of mental health or accredited by a nationally recognized organization.

"Episode" means a distinct course of chemical dependency treatment separated by at least thirty days without treatment.

"Medical detoxification" means Hospital inpatient or residential medical care to ameliorate acute medical condition associated with Chemical Dependency.

"Nonresidential treatment program" means a program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting.

"Mental illness" means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, except for chemical dependency.

"Residential treatment program" means a program certified by the department of mental health involving residential care and structured, intensive treatment.

"Social setting detoxification" means a program in a supportive non-Hospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.

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

Benefits for Mammography

Benefits will be paid the same as any other Sickness for Low-dose Mammography for the presence of occult breast cancer. Benefits will be provided according to the following guidelines:

1. A single baseline mammogram for women thirty-five to thirty-nine years of age.
2. A mammogram not less than once every two years for women forty to forty-nine years of age or more often for women with risk factors to breast cancer if recommended by her Physician.

3. A mammogram every year for women fifty and over.
4. A mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer.

"Low-dose mammography" means the x-ray examination of the breast, using equipment dedicated specifically for mammography including but not limited to the x-ray tub, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

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

Benefits for Prosthetic Device and Reconstructive Surgery

Benefits will be paid the same as any other Sickness for a Mastectomy and prosthetics device or reconstructive surgery necessary to restore symmetry incident to the Mastectomy when recommended by a Physician.

No time limit shall be imposed on an Insured Person for the receipt of prosthetic devices or reconstructive surgery while covered under the policy.

"**Mastectomy**" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

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

Benefits for Cytologic Screening

Benefits will be paid the same as any other Sickness for a pelvic examination and cytologic screening (pap smear) for an Insured in accordance with the current American Cancer Society guidelines.

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 colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic Insured Person in accordance with the current American Cancer Society guidelines.

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

Benefits for Prostate Screening

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer for an Insured in accordance with the current American Cancer Society guidelines.

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

Benefits for Second Opinion for Newly Diagnosed Cancer

Benefits will be paid the same as any other Sickness for a second opinion rendered by a Physician specializing in that specific cancer diagnosis area when an Insured with a newly diagnosed cancer is referred to such Physician specialist by his or her attending Physician.

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

Benefits for Clinical Trials for Cancer Treatment

Benefits will be paid the same as any other Sickness for Routine Patient Care Costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA) regardless of whether approved by the FDA for use in treating the Insured's particular condition for phase II, phase III or phase IV of a clinical trial and is undertaken for the purposes of the prevention, early detection, or treatment of cancer.

For Routine Patient Care Costs for phase II to be considered for payment, the clinical trials must meet all of the following criteria:

1. Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or Nation Cancer Institute Center; and

2. The Insured Person is enrolled in the clinical trial. Coverage for phase II clinical trials will not apply to Insured Persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

For Routine Patient Care Costs for phase III and phase IV to be considered for payment, the clinical trials must meet all of the following criteria:

1. The treatment is provided by (a) one of the National Institutes of Health (NIH); (b) an NIH Cooperative Group or Center; (c) the FDA in the form of an investigational new drug application; (d) the federal Departments of Veterans' Affairs or Defense; (e) an institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or (f) a qualified research entity that meets the criteria for NIH Center support grant eligibility.

2. The treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients.

3. There must be equal or superior noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

4. Any entity seeking coverage for treatment, prevention, or early detection in a clinical trial approved by an institutional review board shall maintain and post electronically a list of the clinical trials meeting the above requirements. The list shall include: (a) the phase for which the trial is approved; (b) the entity approving the trial; (c) the particular disease; and (d) the number of participants in the trial. If electronic posting is not practical, the entity seeking coverage shall periodically provide a written list containing this information.

Providers participating in clinical trials shall obtain the Insured's informed consent for participation on the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to the Company upon request.

"Routine patient care costs" shall include coverage for reasonable and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial including all items and services that are otherwise generally available to a qualified individual except: (a) the investigational item or service itself; (b) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (c) items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

The provisions of this section shall not be construed to affect compliance or coverage for off-label use of drugs not directly affected by this section.

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

Benefits for Human Leukocyte Antigen Testing

Benefits will be paid the same as any other Sickness for Human Leukocyte Antigen Testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Benefits will be limited to one such testing per lifetime.

The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists. At the time of testing, the Insured being tested must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

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

Benefits for Osteoporosis

Benefits will paid the same as any other Sickness for services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a Physician for Insureds with a condition or medical history for which bone mass measurement is medically indicated. In determining whether testing or treatment is medically appropriate, due consideration will be given to peer reviewed medical literature.

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

Benefits for Maternity Expenses

Benefits will be paid the same as any other Sickness for a minimum of 48 hours for inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery. Post-discharge care will be payable for up to two visits by a registered professional nurse with experience in maternal and child health nursing or a Physician, one of which shall be in the home. A Physician shall determine the location and schedule of the post-discharge visits. Services shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization.

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

Benefits for Contraceptives

Benefits will be paid for Contraceptives the same as any other Prescription Drug or device.

“Contraceptives” means all Prescription Drugs and devices approved by the Federal Food and Drug Administration for use as a contraceptive but shall exclude all drugs and devices that are intended to induce an abortion.

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

Benefits for Immunizations

Benefits will be paid the same as any other Sickness for immunizations of a child from birth to five years of age as provided by department of health regulations.

Benefits shall not be subject to any Deductible or Copayment limits.

Benefits for Phenylketonuria

Benefits will be paid the same as any other Sickness for formula and Low Protein Modified Food Products recommended by a Physician for the treatment of phenylketonuria (PKU) or any inherited disease of amino and organic acids for an Insured less than six (6) years of age.

“Low protein modified food products” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

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

Benefits for Newborn Hearing Screening

Benefits will be paid the same as any other Sickness for Dependent Newborn Infants for hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

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

Benefits for Dental General Anesthesia

Benefits will be paid the same as any other Sickness for administration of general anesthesia and Hospital, office, or surgical center charges for dental care to an Insured Person who meets any of the following criteria:

1. Is under the age of five.
2. Is severely disabled.
3. Has a medical or behavioral condition requiring hospitalization or general anesthesia when dental care is provided.

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

Benefits for Autism Spectrum Disorder

Benefits will be paid the same as any other Sickness for Diagnosis and Treatment of Autism Spectrum Disorders. Benefits for Applied Behavior Analysis are limited to Insureds under the age of 19.

Benefits are limited to Medically Necessary treatment that is ordered by the Insured's treating licensed Physician or licensed psychologist, in accordance with a treatment plan. Upon request of the Company, the treatment plan shall include all elements necessary for the Company to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals. Except for Inpatient services, if an Insured is receiving Treatment for an Autism Spectrum Disorder, the Company shall have the right to review the treatment plan not more than once every six months unless the Company and the Insured's treating Physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular Insured being treated for an Autism Spectrum Disorder and shall not apply to all Insureds being treated for Autism Spectrum Disorders by a Physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the Company.

Treatment for Autism Spectrum Disorders" means care prescribed or ordered for an individual diagnosed with an ASD by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, including but not limited to: Psychiatric Care; Psychological Care; Habilitative or Rehabilitative Care, including Applied Behavior Analysis therapy; Therapeutic Care; and Pharmacy care.

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorders" (ASD) means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Diagnosis of autism spectrum disorders" means Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an ASD.

"Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.

"Pharmacy Care" means medication used to address symptoms of an ASD prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the policy.

"Psychiatric Care" means the direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

"Psychological Care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic Care" means services provided by licensed speech therapists, occupational therapists, or physical therapists.

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

Benefits for Chiropractic Care

Benefits will be paid the same as any other Sickness for the chiropractic care delivered by a licensed chiropractor. Benefits will include initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder. Benefits will be provided for the initial twenty-six (26) visits per policy year. In order to receive benefits for any additional visits, the Insured must notify the Company prior to receiving any additional visits. Review of Medical Necessity will be performed for any follow-up diagnostic tests or visits for treatment in excess of the initial twenty-six visits.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy. However, no Copayment will exceed fifty percent of the total cost of any single chiropractic service.

Benefits for Early Intervention Services for Children with Disabilities

Benefits will be paid the same as any other Sickness for Early Intervention Services for children from birth to the age of three (3) when Early Intervention Services are delivered by an early intervention specialist who is a health care professional licensed by the state of Missouri and acting within the scope of their profession.

"Early Intervention Services" means Medically Necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three (3) who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Early Intervention Services include services under an active Individualized Family Service Plan that enhances the functional ability without effecting a cure.

"Individualized Family Service Plan" means a written plan for providing Early Intervention Services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C Section 1436.

The Company shall be billed at the applicable Medicaid rate at the time the covered benefit is delivered and shall pay the Part C early intervention system at such rate for benefits covered by this mandate.

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

Benefits for Telehealth Services

Benefits will be paid on the same basis as services provided through face-to-face consultation or contact between a Physician and an Insured for the diagnosis, consultation, or treatment provided through Telehealth Services.

"Telehealth Services" means the use of medical information exchanged from one site to another via electronic communications to improve the health status of an Insured.
Telehealth Services do not include site origination fees or costs for the provision of Telehealth Services.

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

Benefits for Prosthetic Devices and Services

Benefits will be paid the same as any other Sickness for all Prosthetic Devices and Services, including original and replacement devices, as prescribed by a Physician acting within the scope of his or her practice.

"Prosthetic Devices" shall have the same meaning as described in the federal Medicare program definitions under 42 U.S.C. section 1395x(s)(8) and (9).

"Services" means:

1. Design, fabrication, and customization of the Prosthetic Device.
2. Required visits or fittings with the Prosthetics Device supplier prior to receiving the Prosthetic Device.
3. Proper fitting of the Prosthetic Device.
4. Visits with qualified medical professionals, where such visits are necessary to train the Insured Person in the use of the Prosthetic Device, and visits necessary to train family members or caregivers, if applicable.
5. Post-fitting and adjustment visits after receiving the Prosthetic Device, no less than annually or more frequently if necessary.
6. Necessary modifications after receiving the Prosthetic Device because of physical changes or excessive stump shrinkage.

7. Repair or replacement due to defects in materials and workmanship, to the extent that such is not already covered by a warranty offered by the manufacturer or supplier of the Prosthetic Device.
8. Repair or replacement due to structural integrity issues.
9. Periodic evaluation and patient care in order to assess the Prosthetic Device's effect on the patient's tissues and to assure continued proper fit and function.

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

Mandated Offers of Coverage

The following mandated offers of coverage may be included at the option of the policyholder: Benefits for the treatment of Benefits for Treatment of Speech and Hearing Disorders, Benefits for Child Health Supervision Services, Benefits for Breast Cancer Treatment, and Benefits for Lead Poisoning Testing.

Coordination of Benefits Provision

Definitions

(1) **Allowable Expenses:** Any health care expense, including coinsurance, or copayments and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.

(a) The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.
(b) For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
(c) For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
(d) If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

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

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

Plan includes all of the following:
(a) Group insurance contracts and subscriber contracts.
(b) Uninsured arrangements of group or group-type coverage.
(c) Group coverage through closed panel plans.
(d) Group-type contracts, including blanket contracts.
(e) The medical care components of long-term care contracts, such as skilled nursing care.
(f) The medical benefits coverage in group, group-type, and individual automobile no fault type contracts.
(g) The medical benefits coverage in group and group-type traditional automobile fault type contracts.

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

Plan does not include any of the following:
(a) Hospital indemnity coverage benefits or other fixed indemnity coverage.
(b) Accident only coverage.
(c) Limited benefit health coverage as defined by state law.
(d) Specified disease or specified accident coverage.
(e) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis.
(f) Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
(g) Medicare supplement policies.
(h) State Plans under Medicaid.
(i) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
(j) An Individual Health Insurance Contract.

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

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

(5) **We, Us or Our:** The Company named in the policy to which this benefit is attached.

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

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

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

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

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

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

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

(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the plan covering the person as a dependent; and (ii) primary to the plan covering the person as other than a dependent, then the order of benefit is reversed. The plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(2) Dependent Child/Parents Married or Living Together. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:

(a) the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
(b) However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

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

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

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

If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:

(a) First, the Plan of the parent with custody of the child.
(b) Then Plan of the spouse of the parent with the custody of the child.
(c) The Plan of the parent not having custody of the child.
(d) Finally, the Plan of the spouse of the parent not having custody of the child.

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

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

(6) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

(a) First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
(b) Second, the benefits under the COBRA or continuation coverage.
(c) If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

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

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

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations. The Company shall not request a refund or offset a claim more than twelve months after the Company has paid the claim, except in cases of fraud or misrepresentation by the health care provider.

Continuation Privilege

An Insured Person whose coverage ends under this policy may be entitled to elect continuation of coverage (coverage that continues on in some form) in accordance with applicable state and federal law.

Subject to the following terms and conditions, each Qualified Beneficiary who has been continuously insured under the school's student insurance policy, who no longer meets the Eligibility requirements under the school's student insurance policy, and who loses coverage as a result of a Qualifying Event is eligible to continuation of coverage under the school's student insurance policy then in effect as may be required for student health insurance policies by applicable federal or state law, not to exceed the Maximum Period of Coverage allowed. If the Insured is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase the remainder of the continuation of coverage under the school's student policy in effect.

Qualified beneficiary means:

- The Named Insured who is covered under the group policy on the day before a Qualifying Event.
- Any Dependent child or spouse who is covered under the group policy on the day before a Qualifying Event.

Qualifying event means any of the following events which result in the loss of coverage of a Qualified Beneficiary:

- Termination of coverage due to loss of eligibility of the Named Insured.
- Death of the Named Insured.
- The divorce or legal separation of the Named Insured.

Maximum Period of Continuation of Coverage:

The maximum period of continuation of coverage allowed is:

- Loss of Eligibility - in the case of a Qualifying Event for termination of coverage due to loss of eligibility of the Named Insured, a maximum of 18 months after the date of the Qualifying Event.
    - If the Insured has an additional Qualifying Event during the initial 18 month coverage period, a maximum of 36 months after the date of the initial Qualifying Event.
- Other Qualifying Events - In the case of termination of coverage due to all other Qualifying Events, a maximum of 36 months after the date of the Qualifying Event.
- Disability - If the Insured becomes disabled, as determined under title II or XVI of the Social Security Act, at any time during the first 60 days of continuation of coverage, no more than 29 months after the date of the initial Qualifying Event but only if the Insured has provided notice of such disability determination before the end of the initial 18 month period. The Insured must notify the company of such determination within 60 days after the date of the determination.

Notification and Election Requirements:

This provision serves as written notice to all Insured Persons and Qualified Beneficiaries of the rights to continuation of coverage as described herein.

The Qualified Beneficiary must enroll and pay the required premium within 60 days of the date coverage terminates under this policy by reason of a Qualifying Event. Coverage becomes effective on the date of the Qualifying Event provided the enrollment and premium payment deadlines are met.

Application must be made and premium must be paid directly to UnitedHealthcare**Student**Resources. Contact UnitedHealthcare**Student**Resources at (800) 767-0700 for application and additional information.

Termination of Coverage:

Continuation of coverage under this Policy terminates on the earlier of:

- The date this policy terminates.
- The date the Policyholder no longer provides a student group policy.
- The end of the period through which timely premium payment is made. The payment of any premium will be considered timely if made within 30 days after the date due.
- The date the Insured first becomes eligible for coverage under another group health plan.
- The date the Insured becomes entitled to benefits under Medicare.
- The date required by applicable federal or state law.
- In the case of an Insured who is disabled at any time during the first 60 days of continuation of coverage, the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the Insured is no longer disabled. The Insured must notify the company within 30 days after the date of such final determination.

Definitions

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

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

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 date of placement: 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 date of placement.

Placement means the physical custody of the adoptive parent.

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

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to 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. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years. If the child is covered under this policy upon the attainment of the limiting age, such child shall remain a dependent under this policy at the option of the Named Insured until the policy Termination Date.

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 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, investigational, or unproven; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means with respect to a Medical Emergency:

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

EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICE means medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

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

2. Subject to review and approval by any institutional review board for the proposed use; or

3. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

4. Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

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 24 hour nursing service by Registered Nurses on duty or call; 5) provides organized facilities for diagnosis 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 accidental bodily injury sustained directly and independently of all other causes; treated by a Physician within 30 days after the date of the accident and while the Insured Person is covered under this policy.

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, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which benefits are payable under this policy.

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

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the 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 close observation by trained and qualified personnel whose duties are primarily confined to such part of the Hospital. 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 the occurrence of a sudden and at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that immediate medical care is required, which may include, but shall not be limited to:

1. Death.
2. Placement of the Insured's health in significant jeopardy.
3. Serious impairment of bodily functions.
4. Serious dysfunction of any body organ or part.
5. Inadequately controlled pain.
6. With respect to a pregnant woman who is having contractions:
    - That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
    - That transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

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 any condition or disorder defined by categories listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders,* except for chemical dependency.

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; hearing screening, necessary rescreening, audiological assessment and follow-up and initial amplification; 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) notify the Company of the birth either orally or in writing; 2) complete and return the enrollment form; and 3) pay the required additional premium, if any, for the continued coverage. The Insured will have an additional ten (10) days from the date the required forms and instructions are provided to enroll the newly born child. 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 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.

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Named Insured unable to actively attend class. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

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. Acupuncture.

2. 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.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
   - Correct hemangiomas and port wine statins of the head and neck areas for Insureds age 18 years and younger.
   - Correct limb deformities such as club hand, club foot, syndactyly, polydactyly, or macrodactylia.
   - Improve hearing by directing sound in the ear canal by performing Otoplasty, when ear or ears are absent or deformed from Injury, surgery, disease, or Congenital Condition.
   - Correct diagnosis of tongue-tied by performing tongue release.
   - Treat or correct Congenital Conditions causing skull deformity such as Crouzon's disease.
   - Correct cleft lip and cleft palate.

3. 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.

4. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As specifically provided in Benefits for Dental General Anesthesia.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.

5. Elective Surgery or Elective Treatment.

6. Elective abortion.

7. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.

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

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

9. Hirsutism. Alopecia.

10. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of an infection or Injury.
    - Benefits for Newborn Hearing Screening as specifically provided in the policy.
    - Benefits for Treatment of Speech and Hearing Disorders.

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

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 sustained while:
    - Participating in any club, 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.

14. Investigational services.

15. Lipectomy.

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

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.
    - 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.
    - Fertility tests.
    - 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.
    - 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 Benefits for Clinical Trial for Cancer Treatment.

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.
    - To the first pair of eyeglasses or contact lenses following intraocular lens implantation for the treatment of cataracts or aphakia or to replace the function of the human lens for conditions caused by cataract surgery or Injury.

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

22. Preventive care services, except as specifically provided in the policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.

23. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.

24. Skeletal irregularities of one or both jaws, except for temporomandibular and craniomandibular joint or jaw disorders. 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.
25. Sleep disorders.

26. Speech therapy, except as specifically provided in the policy.

27. Medical supplies, except as specifically provided in the policy.

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

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

30. 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 notice for such period not covered).

31. 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.

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to ***My Account*** at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "create **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 **Student**Resources' environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account now includes Message Center - a self-service tool that provides a quick and easy way to view any email notifications 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. A written notice of claim must be submitted to the address below within 90 days after expense is incurred, or as soon thereafter as reasonably possible. Upon receipt of a notice of claim, the Company will furnish the Insured the necessary forms for filing proof of loss. If the person making claim does not receive the necessary claim forms before the expiration of 15 days after first requesting such forms, the Insured shall be deemed to have complied with the requirements as to the proof of loss upon submitting to the Company within 90 days written proof covering the occurrence, character and extent of the loss for which claim is made.

4. Submit claims for payment within 90 days after the date of service. The Insured's failure to give notice within such time will not invalidate nor reduce any claim if it is shown that notice was given as soon as reasonably possible. 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 **Student**Resources
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.

Pre-Authorization

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

Section 2: Benefits for Pediatric Dental Services

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

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

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.
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%
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.	50%	50%
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 Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 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.
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%
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. All orthodontic treatment must be prior authorized.		
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. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the policy.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network 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:

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
Phone: 1-800-255-8361

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 provision.

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

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
• Eyeglass frames with a retail cost of $130 - 160.		100% after a Copayment of $15.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - 200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - 250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.
Contact Lenses	Limited to a 12 month supply.		
• Covered Contact Lens Selection		100% after a Copayment of $40.	50% of the billed charge.
• 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.			
• Low Vision Testing		100% of the billed charge.	75% of the billed charge.
• Low Vision Therapy		100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided 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:

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
Phone: (1-844-255-8361)

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:

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
Phone: (1-844-255-8361)

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

DEFINITIONS

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

Adverse Determination means:

1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care,

or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy as an Insured Person;
3. Any concurrent, prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy; or
4. A rescission of coverage.

Authorized Representative means:

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

Concurrent Review means Utilization Review conducted during a patient's Inpatient hospital stay or course of treatment.

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

Grievance means a written compliant submitted by or on behalf of an Insured Person regarding the:

1. Availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review
2. Claims payment, handling or reimbursement for health care services; or
3. Matters pertaining to the contractual relationship between an Insured Person and a health carrier.

Prospective Review means Utilization Review performed prior to an admission or course of treatment.

Retrospective Review means Utilization Review of Medical Necessity conducted after services have been provided to a patient. Retrospective review does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

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

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

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

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, Second Opinion, certification, Concurrent Review, case management, discharge planning, or Retrospective Review.

The Insured Person has the right to contact the Division of Consumer Affairs within the Missouri Department of Insurance for assistance with appeals at any time.

The Division can be contacted at the following address and telephone number:

Missouri Department of Insurance, Financial Institutions and Professional Registration
Consumer Affairs Division
301 W. High Street, Room 830
Harry S. Truman State Office Building
Jefferson City, MO 65101
(800) 726-7390
www.insurance.mo.gov
consumeraffairs@insurance.mo.gov

INTERNAL APPEAL PROCESS

First Level Appeal

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

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.

The Customer Service Department can be contacted at 1-844-255-8361with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: HealthSmart Benefit Solutions, Inc. 3320 West Market Street, Suite 100 Fairlawn, OH 44333-3306.

Upon receipt of the request for a first level Internal Review of a Grievance, the Company shall, within 10 working days acknowledge receipt of the request for an appeal and provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination.

Within 3 days after receipt of a Grievance involving an Adverse Determination, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

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

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

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

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

The company shall complete an investigation within 20 working days after receipt of the Grievance. If the investigation cannot be completed within 20 working days, the Insured Person or Authorized Representative will be notified in writing on or before the twentieth working day with the specific reasons for which additional time is needed for the investigation. The investigation shall then be completed within 30 working days thereafter.

Within 5 working days after the investigation has been completed, the Company shall notify the Insured or Authorized Representative in writing of the Company's decision regarding the Grievance and of the right to file a second level appeal.

Within 15 days after the investigation has been completed, the Company shall also notify the person who submitted the Grievance of the Company's resolution of said Grievance.

Second Level Appeal

Within 180 days after receipt of a notice of the resolution of the first level Grievance an Insured Person or an Authorized Representative may submit a written request for a second level Internal Review of a that Grievance.

Upon receipt of a second level appeal request, the Company shall submit the Grievance to a Grievance advisory panel. The Grievance advisory panel shall consist of:

1. Other Insureds;
2. Representative of the Company who was not involved in the circumstances giving rise to the Grievance or Adverse Determination; and
3. Where the Grievance involves an Adverse Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the Grievance or Adverse Determination.

The company shall complete an investigation within 20 working days after receipt of the Grievance. If the investigation cannot be completed within 20 working days, the Insured Person or Authorized Representative will be notified in writing on or before the twentieth working day with the specific reasons for which additional time is needed for the investigation. The investigation shall then be completed within 30 working days thereafter.

Within 5 working days after the investigation has been completed, the Company shall notify the Insured or Authorized Representative in writing of the Company's decision regarding the Grievance and of the right to file an appeal of the decision with the Consumer Affairs Division of the Missouri Department of Insurance. The notice shall include the Division's toll-free phone number and address.

Within 15 days after the investigation has been completed, the Company shall also notify the person who submitted the Grievance of the Company's resolution of said Grievance.

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

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

5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation; and
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction.
7. Notice of the Insured Person's right to contact the Division of Consumer Affairs for assistance with respect to any claim, Grievance or appeal at any time.

Expedited Internal Review (EIR) of a Grievance

The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of a Grievance involving a situation where the time frame of the standard first and/or second level appeals would seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function.

For the purposes of Missouri's Grievance register requirements, the EIR request will not be considered a Grievance unless the request is submitted in writing.

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

The Insured Person or the Authorized Representative shall be notified orally of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request. Written confirmation of the decision will be provided within three (3) working days of providing oral notification of the determination.

EXTERNAL INDEPENDENT REVIEW

An Insured Person or Authorized Representative may file a Grievance with the Consumer Affairs Division of the Missouri Department of Insurance when the Insured has received an Adverse Determination or Final Adverse Determination from the Company. The Insured Person or Authorized Representative may submit a request for an External Independent Review without exhausting all remedies available under the Company's Grievance process.

The Division can be contacted at the following address and telephone number:

Missouri Department of Insurance, Financial Institutions and Professional Registration
Consumer Affairs Division
301 W. High Street, Room 830
Harry S. Truman State Office Building
Jefferson City, MO 65101
(800) 726 7390
www.insurance.mo.gov
consumeraffairs@insurance.mo.gov

I. Standard External Review Process

1. After the Grievance is received, the Director shall attempt to resolve as a consumer complaint and resolve the issue with the Company. If the Director determines the issue cannot be resolved, the Director shall:
2. Refer the unresolved Grievance to an Independent Review Organization from the Director's approved list.
3. Provide the IRO, Insured Person or their Authorized Representative, or the Company with copies of all medical records or any other relevant documents which the Division has received from any party.
4. The Insured Person, Authorized Representative, or the Company may submit additional information to the Division, which the Division will forward to the IRO for consideration when conducting the review. If the Insured Person, Authorized Representative, or the Company has information which contradicts information already provided to IRO, then this information must be provided as additional information. All additional information should be received by the Division within 15 working days from the date the Division mailed that party copies of the information provided to the IRO
5. If the IRO should request from the Division additional information needed; the Division shall gather the requested information from the Company, Insured Person or, if applicable, the Authorized Representative and provide it to the IRO. If the Division is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.

6. Within 20 days after receipt of the request for external review, the IRO shall provide, to the Director, its opinion to uphold or reverse the Adverse Determination or Final Adverse Determination. Under exceptional circumstances, if the IRO requires additional time to complete its review, the IRO will request in writing from the Director an extension in the time to process the review, which will not exceed 5 calendar days.
7. After the Director receives the IRO's decision, the Director shall, within 25 calendar days of receiving the IRO's opinion, provide written notice of the Director's decision to uphold or reverse the Adverse Determination or Final Adverse Determination to the, the Company, the Insured Person and, if applicable, the Authorized Representative. In no event shall the time between the date the IRO receives the request for external review and the date the Insured and the Company are notified of the Director's decision be longer than 45 days.
8. The Director's decision shall be binding upon the Insured Person and the Company.

Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

II. Expedited External Review Process

1. The Insured Person or an Authorized Representative may make a request for an Expedited External Review (EER) with the Director at the time the Insured Person receives:
   (i) An Adverse Determination involving a medical condition for which the timeframe 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
   (ii) An Adverse Determination involving an admission, availability of care, continued stay or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

   An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.
2. As expeditiously as possible after receipt of the request for an EER by the IRO, the IRO must issue its opinion as to whether the Adverse Determination should be upheld or reversed and submit its opinion to the Division.
3. As expeditiously as possible, but within no more than 72 hours after receipt of the qualifying EER request, the Division shall then issue a decision. If the notice is not in writing, the Division will provide the written decision within 48 hours after the date of the notice of determination.
4. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

III. Experimental or Investigational Treatment External Review Process

1. If a request for external review of an Adverse Determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the following additional requirements must be met.
2. The IRO will complete a preliminary review to determine that:
   a. The recommended healthcare service or treatment subject to the Adverse Determination or Final Adverse Determination is a covered benefit under the Policy; and
   b. The recommended healthcare service or treatment subject to the Adverse Determination or Final Adverse Determination is not explicitly listed as an excluded benefit under the Policy.
3. The request for external review of an Adverse Determination involving a denial of coverage based on the Company's determination that the health care service or treatment recommended or requested is experimental or investigational must include a certification from the Insured Person's Physician stating:
   a. Standard health care services or treatments have not been effective in improving the condition of the Insured Person, or
   b. Standard health care services or treatments are not medically appropriate for the Insured Person; or
   c. There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment; and
   d. The request for external review of an Adverse Determination involving the denial of coverage based on a determination that the requested treatment is experimental or investigational shall also include documentation that:
      i. The Insured Person's treating Physician has recommended a health care service or treatment that the Physician certifies, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion than any available standard health care services or treatments; or
      ii. That the Insured Person's treating Physician, who is a licensed, board-certified, or board-eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or

treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care service or treatment.

4. When conducting the external review of an Adverse Determination or Final Adverse Determination involving a denial of coverage based on a determination the health care service or treatment is experimental or investigational, the IRO shall select 1 or more clinical peers who must be Physicians or other health care professionals who meet minimum qualifications and through clinical experience in the past 3 years are experts in the treatment of the Insured's condition and knowledgeable about the recommended or requested health care service or treatment.
5. Each clinical reviewer shall provide written opinion to the IRO to uphold or reverse the Adverse Determination or Final Adverse Determination. The IRO shall provide the opinions to the Division who shall then issue the decision to either uphold or reverse the Adverse Determination or Final Adverse Determination with the same time frames for the standard and expedited external review procedures.
6. Upon receipt of the Director's notice of a decision reversing an Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

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

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Submit all Claims to:

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

Claims Status and all other Claim Inquires:

Claims Administrator
HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
1-800-255-8361

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 # 2016-202864-4.