

UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT INJURY AND SICKNESS INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of

Missouri State University

2017-2018

This Certificate of Coverage is Part of Policy # 2017-202864-4

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

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

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



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Introduction

Welcome to the UnitedHealthcare StudentResources Student Injury and Sickness Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance Company (“the Company”).

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

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

To receive the highest level of benefits from the plan, the Insured Person should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the plan’s web site at www.uhcsr.com. The web site will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at 1-844-255-8361, toll free, for assistance in finding a Preferred Provider.

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-844-255-8361. The Insured can also write to the Company at:

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

Section 1: Who Is Covered

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

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

International students with an F-1 or J-1 visa status (including ESL students) are required to purchase this insurance plan on a mandatory basis.

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

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

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

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

Dependent eligibility expires concurrently with that of the Named Insured.

Section 2: Effective and Termination Dates

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

The Master Policy terminates at 11:59 p.m., August 9, 2018. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is 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.

Section 4: 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. A list of Preferred Providers is located on the plan's web site at www.uhcsr.com. 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 (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.

Section 5: Medical Expense Benefits – Injury and Sickness

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

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

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.**
Physician's fees for Inpatient surgery.
6. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with Inpatient surgery.
7. **Anesthetist Services.**
Professional services administered in connection with Inpatient surgery.

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

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

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

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

9. **Physician's Visits.**

Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**

Benefits are limited to routine tests such as:

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

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

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

Outpatient

11. **Surgery.**

Physician's fees for outpatient surgery.

12. **Day Surgery Miscellaneous.**

Facility charge and the charge for services and supplies in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.

13. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with outpatient surgery.

14. **Anesthetist Services.**

Professional services administered in connection with outpatient surgery.

15. **Physician's Visits.**

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. 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.**

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.**

Only in connection with a Medical Emergency as defined. Benefits will be paid for Emergency Services and 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.**

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

19. **Radiation Therapy.**

See Schedule of Benefits.

20. **Laboratory Procedures.**

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

21. **Tests and Procedures.**

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

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

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

- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.

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

22. **Injections.**

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

23. **Chemotherapy.**

See Schedule of Benefits.

24. **Prescription Drugs.**

See Schedule of Benefits. 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 for the dispensing of the combination of the manufactured dosages that equal the prescribed dosage for such Prescription Drug will apply. A new Copayment 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 need, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

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 Device and Reconstructive Breast 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 the Policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.

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

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

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

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

45. **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.

46. **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.

47. **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.

Section 6: Mandated Benefits

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. Outpatient treatment through partial or full Day Program Services.
2. 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.
3. Inpatient treatment.
4. 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 DIAGNOSIS AND TREATMENT OF EATING DISORDERS

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of an Eating Disorder. Benefits will be provided for Medically Necessary treatment provided by a licensed treating Physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist acting within the scope of his or her license, in accordance with a treatment plan.

Upon request from the Company, the treatment plan must include, but is not limited to, the following elements:

1. Diagnosis.
2. Proposed treatment by type.
3. Frequency and duration of treatment.
4. Goals.

Coverage for the treatment of Eating Disorders will not be based solely on weight. Consideration for Medically Necessary coverage will be given using the most recent Practice Guideline for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association in addition to current standards based upon the medical literature generally recognized as authoritative in the medical community.

"Eating disorder" means Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specified Feeding or Eating Disorder, and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association where diagnosed by a licensed physician, psychiatrist, psychologist, clinical social worker, licensed marital and family therapist, or professional counselor duly licensed in the state where he or she practices and acting within their applicable scope of practice in the state where he or she practices.

"Treatment of eating disorders", means therapy provided by a licensed treating physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed physician's, psychiatrist's, psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license in the state where he or she practices for an individual diagnosed with an eating disorder.

"Medical care" means health care services needed to diagnose, prevent, treat, cure, or relieve physical manifestations of an eating disorder, and shall include inpatient hospitalization, partial hospitalization, residential care, intensive outpatient treatment, follow up outpatient care, and counseling.

"Pharmacy care" means medications prescribed by a licensed physician for an eating disorder and includes any health-related services deemed medically necessary to determine the need or effectiveness of the medications, but only to the extent that such medications are included in the insured's health benefit plan.

"Psychiatric care" and "psychological care", direct or consultative services provided during inpatient hospitalization, partial hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care, and counseling provided by a psychiatrist or psychologist licensed in the state of practice.

"Therapy" means medical care and behavioral interventions provided by a duly licensed physician, psychiatrist, psychologist, professional counselor, licensed clinical social worker, or family marriage therapist where said person is licensed or registered in the states where he or she practices.

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 BREAST 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 National 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 be 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 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.

“Habilitation 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.

BENEFITS FOR LEAD POISONING TESTING

Benefits will be paid the same as any other Sickness for lead poisoning testing of children less than six (6) years of age and pregnant women.

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

Section 7: Coordination of Benefits Provision

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

Definitions

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

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

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

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

Plan includes all of the following:

- Group insurance contracts and subscriber contracts.
- Uninsured arrangements of group or group-type coverage.
- Group coverage through closed panel Plans.
- Group-type contracts, including blanket contracts.
- The medical care components of long-term care contracts, such as skilled nursing care.
- The medical benefits coverage in group, group-type, and individual automobile no fault type contracts.
- The medical benefits coverage in group and group-type traditional automobile fault type contracts.
- Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of Plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

Plan does not include any of the following:

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

3. **Primary Plan:** A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.
4. **Secondary Plan:** A Plan that is not the Primary Plan.
5. **We, Us or Our:** The Company named in the Policy.

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

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

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

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

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

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

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

1. **Non-Dependent/Dependent.** The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the Plan covering the person as a dependent; and (ii) primary to the Plan covering the person as other than a dependent, then the order of benefit is reversed. The Plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.
2. **Dependent Child/Parents Married or Living Together.** When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:
 - the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
 - However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
3. **Dependent Child/Parents Divorced, Separated or Not Living Together.** If two or more Plans cover a person as a Dependent child of parents who are divorced or separated or are not living together, whether or not they have ever been married, benefits for the child are determined in this order:

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

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

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

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

- First, the Plan of the parent with custody of the child.
- Then the Plan of the spouse of the parent with the custody of the child.
- The Plan of the parent not having custody of the child.
- Finally, the Plan of the spouse of the parent not having custody of the child.

4. **Dependent Child/Non-Parental Coverage.** If a Dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as if those individuals were parents of the child.
5. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
 - Second, the benefits under the COBRA or continuation coverage.
 - If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

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

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

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

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

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

Section 8: Student Health Center (SHC) Referral Required – Taylor Health and Wellness Center

The student and Spouse should use the services of the Health Center first where 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 will be paid at the Out-of-Network level of benefits as specified in the Schedule of Benefits. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

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

1. Medical Emergency. The student 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.

Section 9: Continuation Privilege

An Insured Person whose coverage ends under the 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 the 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 premiums must be paid directly to UnitedHealthcare **StudentResources**. Contact UnitedHealthcare **StudentResources** at (844) 255-8361 for application and additional information.

Termination of Coverage:

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

- The date the 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.

Section 10: Definitions

ADOPTED CHILD means the adopted child placed with an Insured while that person is covered under the 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.

Coverage begins at the moment of birth or date of placement if a written agreement to adopt such child has been entered into by the Insured prior to the birth or date of placement 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. Coverage will include Medically Necessary care and treatment of medical conditions existing prior to the date of placement.

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

DEPENDENT means the legal spouse of the Named Insured and their dependent children. 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 the Policy upon the attainment of the limiting age, such child shall remain a dependent under the 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 and treated by a Physician within 30 days after the date of the accident and while the Insured Person is covered under the Policy. Covered Medical Expenses incurred as a result of an injury that occurred prior to the Policy's Effective Date will be considered a Sickness under the Policy.

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

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

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

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under 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:
 - a. That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
 - b. 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.

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

MENTAL ILLNESS means a Sickness that is 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 Policy; and 2) the appropriate premium for coverage has been paid.

NEWBORN INFANT means any child born of an Insured while that person is insured under the Policy. 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 Person will have an additional 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 OR MASTER POLICY means the entire agreement issued to the Policyholder that includes all of the following:

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

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

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

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 the Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to the Policy's Effective Date will be considered a sickness under the Policy.

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

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

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

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 maximum amount the Policy is obligated to pay for services. Except as otherwise required under state or federal regulations, usual and customary charges will be the lowest of:

1. The billed charge for the services.
2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered.
3. An amount determined using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical difference where applicable, plus a margin factor.

The Company uses data from FAIR Health, Inc. and/or Data iSight to determine Usual and Customary Charges. Usual and Customary Charges determined using data from FAIR Health, Inc. will be calculated at the 75th percentile. No payment will be made under the Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Section 11: 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 the Policy. The primary result of the procedure is not a changed or improved physical appearance.
 - Treat or correct birth defects and birth abnormalities.
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. 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.
10. Hirsutism. Alopecia.
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 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.
 - 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, except as specifically provided in the Policy:
 - 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, except to diagnose or treat the underlying cause of the infertility.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Reversal of sterilization procedures.
 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 Trials 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 which are not 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.

Section 12: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. 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 **StudentResources**
P.O. Box 809025
Dallas, TX 75380-9025

Section 13: General Provisions

GRACE PERIOD: The Insured is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the Policy shall continue in force, unless the Insured has given the Company written notice of discontinuance in advance of the date of discontinuance. The Insured shall be liable to the Company for the payment of a pro-rata premium for the time the Policy was in force during such grace period.

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

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid upon receipt of due written proof of such loss. If the Company has not processed the claim within thirty (30) working days of receipt of a filed claim, the Company will send an electronic or facsimile notice of the status of a claim that includes a request for additional information. The Company will send an electronic acknowledgement receipt of an electronic claim within forty-eight (48) hours of receipt.

Within ten (10) processing days after receipt by the Company of any requested additional information, the Company shall pay the claim or any undisputed part of the claim or send a notice of receipt and the status of the claim: (i) that denies all or part of the claim and specifies each reason for denial; or (ii) that makes a final request for additional information. Within five (5) processing days after the Company receives the final additional information, the Company shall pay the claim or any undisputed part of the claim or deny the claim. If the Company has not paid the claim on or before the forty-fifth processing day after receipt of due written proof of such loss, the Company shall pay the claimant one percent interest per month. The interest shall be calculated based upon the unpaid balance of the claim as of the forty-fifth processing day. The interest paid shall be included in any late reimbursement without the necessity for the claimant that filed the original claim to make an additional claim for that interest. The Company may combine interest payments and make payment once the aggregate amount reaches one hundred (100) dollars.

If the Company fails to pay, deny or suspend the claim within forty-five (45) processing days, the Company shall, in addition to monthly interest due, pay to the claimant per day an amount equal to one percent of the claim. Said interest and penalties shall cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of said claim. Upon a finding by a court of competent jurisdiction that the Company failed to pay a claim, interest or penalty without reasonable cause, the court shall enter judgment for reasonable attorney fees for services necessary for recover. Upon a finding that a provider filed suit without reasonable grounds to recover a claim, the court shall award the Company reasonable attorney fees necessary to the defense.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured. Any other accrued indemnities unpaid at the Insured's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured. If any indemnity of the Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$2,000, to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. All other benefits of the Policy shall be payable to the Insured, unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss.

The benefits payable hereunder shall be paid, with or without an assignment from the Insured, to public hospitals or clinics for services and supplies provided to an Insured if a proper claim is submitted by the public hospital or clinic. No benefits shall be paid under this section to the public hospital or clinic if such benefits have been paid to the Insured prior to receipt of the claim by the Company. Payment to the public hospital or clinic of benefits pursuant to this section shall discharge the Company from all liability to the Insured to the extent of the benefits so paid. Nothing in this section shall be construed to require payment of benefits for the same services or supplies to both the Insured and the public hospital or clinic.

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

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made. The Company shall not request a refund or offset a claim more than twelve (12) months after the Company has paid the claim, except in cases of fraud or misrepresentations by the health care provider.

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

Section 14: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL

Standard Internal Appeal

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

Please contact the Customer Service Department at 1-844-255-8361 with 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.

First Level Internal Appeal Process

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

Upon receipt of the request for 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; and
2. Any new or additional rationale upon which the decision was based.

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

The Company shall 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 the 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 Internal Appeal Process

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 receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
 - d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
 - e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
 - f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
7. Notice of the Insured Person's right to contact the Division of Consumer Affairs for assistance with respect to any claim, Grievance or appeal at any time.

Expedited Internal Review of a Grievance

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

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

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

To request an Expedited Internal Appeal, please contact HealthSmart Benefit Solutions at 1-844-255-8361. The written request for an Expedited Internal Appeal should be sent to: HealthSmart Benefit Solutions, Inc. 3320 West Market Street, Suite 100 Fairlawn, OH 44333-3306.

Expedited Internal Review Process

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

RIGHT TO 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

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:
 - a. Refer the unresolved Grievance to an Independent Review Organization from the Director's approved list.
 - b. 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.
2. 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
3. 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.
4. 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.
5. 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.
6. The Director's decision shall be binding upon the Insured Person and the Company.
7. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review 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:
 - a. 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
 - b. 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.

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 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.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance department at the following address:

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

APPEAL RIGHTS DEFINITIONS

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

Adverse Determination means:

1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy as an Insured Person;
3. Any 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 complaint 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, the 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.

Questions Regarding Appeal Rights

Contact Customer Service at 1-844-255-8361 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Section 15: Important Company Contact Information

The Policy is Underwritten by:

UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:

UnitedHealthcare **StudentResources**

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

Section 16: Pediatric Dental Services Benefit

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

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

Network Benefits - these benefits apply when the Insured Person chooses to obtain Covered Dental Services from a Network Dental Provider. Insured Persons generally are required to pay less to the Network Dental Provider than they would pay for services from 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 Person 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. The Insured Person can verify the participation status by calling the Company and/or the provider. If necessary, the Company can provide assistance in referring the Insured Person to 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 844-255-8361 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 - these 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, Insured Persons 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 Person must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

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

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

Pre-Treatment Estimate

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

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

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

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 Exclusions*.

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

Network Benefits:

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

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

Non-Network Benefits:

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

Dental Services Deductible

Benefits for pediatric Dental Services provided 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 applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*.

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

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

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

Benefit Description

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 - (Subject to payment of the Dental Services Deductible.)		
<p><i>Evaluations (Checkup Exams)</i></p> <p><i>Limited to 2 times per 12 months.</i></p> <p>Covered as a separate benefit only if no other service was done during the visit other than X-rays.</p> <p>D0120 - Periodic oral evaluation</p> <p>D0140 - Limited oral evaluation - problem focused</p> <p>D0150 - Comprehensive oral evaluation</p> <p>D0180 - Comprehensive periodontal evaluation</p> <p><i>The following service is not subject to a frequency limit.</i></p> <p>D0160 - Detailed and extensive oral evaluation - problem focused</p>	50%	50%
<p><i>Intraoral Radiographs (X-ray)</i></p> <p><i>Limited to 2 series of films per 12 months.</i></p> <p>D0210 - Complete series (including bitewings)</p>	50%	50%
<p><i>The following services are not subject</i></p>	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.
<p><i>to a frequency limit.</i></p> <p>D0220 - Intraoral - periapical first film D0230 - Intraoral - periapical - each additional film D0240 - Intraoral - occlusal film</p>		
<p><i>Any combination of the following services is limited to 2 series of films per 12 months.</i></p> <p>D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films D0277 - Vertical bitewings</p>	50%	50%
<p><i>Limited to 1 time per 36 months.</i></p> <p>D0330 - Panoramic radiograph image</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D0340 - Cephalometric X-ray D0350 - Oral/Facial photographic images D0391 - Interpretation of diagnostic images D0470 - Diagnostic casts</p>	50%	50%
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
<p><i>Dental Prophylaxis (Cleanings)</i></p> <p><i>The following services are limited to 2 times every 12 months.</i></p> <p>D1110 - Prophylaxis - adult D1120 - Prophylaxis - child</p>	50%	50%
<p><i>Fluoride Treatments</i></p> <p><i>The following services are limited to 2 times every 12 months.</i></p> <p>D1206 and D1208 - Fluoride</p>	50%	50%
<p><i>Sealants (Protective Coating)</i></p> <p><i>The following services are limited to once per first or second permanent molar every 36 months.</i></p> <p>D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth</p>	50%	50%
<p><i>Space Maintainers (Spacers)</i></p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D1510 - Space maintainer - fixed -</p>	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.
unilateral D1515 - Space maintainer - fixed - bilateral D1520 - Space maintainer - removable - unilateral D1525 Space maintainer - removable bilateral D1550 - Re-cementation of space maintainer		
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
<i>Amalgam Restorations (Silver Fillings)</i> <i>The following services are not subject to a frequency limit.</i> D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	50%	50%
<i>Composite Resin Restorations (Tooth Colored Fillings)</i> <i>The following services are not subject to a frequency limit.</i> D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
<i>The following services are subject to a limit of 1 time every 60 months.</i> D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four surfaces D2740 - Crown - porcelain/ceramic substrate D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal	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.
<p>D2780 - Crown - 3/4 case high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 Crown – titanium D2929 – Prefabricated porcelain crown - primary D2930 Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth</p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D2510 Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement inlay D2920 - Re-cement crown</p>		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D2940 - Protective restoration</p>	50%	50%
<p><i>The following service is limited to 1 time per tooth every 60 months.</i></p> <p>D2950 - Core buildup, including any pins</p>	50%	50%
<p><i>The following service is limited to 1 time per tooth every 60 months.</i></p> <p>D2951 - Pin retention - per tooth, in addition to Crown</p>	50%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D2954 - Prefabricated post and core in addition to crown</p>	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.
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D2980 - Crown repair necessitated by restorative material failure D2981 – Inlay repair D2982 – Onlay repair D2983 – Veneer repair D2990 – Resin infiltration/smooth surface</p>	50%	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3220 - Therapeutic pulpotomy (excluding final restoration)</p>	50%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3222 - Partial pulpotomy for Apexogenesis - Permanent tooth with incomplete root development</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D3310 - Anterior root canal (excluding final restoration) D3320 - Bicuspid root canal (excluding final restoration) D3330 - Molar root canal (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification - interim medication replacement D3353 - Apexification/recalcification - final visit</p>	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.
<i>The following service is not subject to a frequency limit.</i> D3354 - Pulpal Regeneration	50%	50%
<i>The following services are not subject to a frequency limit.</i> D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root	50%	50%
<i>The following service is not subject to a frequency limit.</i> D3450 - Root amputation - per root	50%	50%
<i>The following service is not subject to a frequency limit.</i> D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
<i>The following services are limited to a frequency of 1 every 36 months.</i> D4210 - Gingivectomy or gingivoplasty - four or more teeth D4211 - Gingivectomy or gingivoplasty - one to three teeth D4212 - Gingivectomy or gingivoplasty - with restorative procedures - per tooth	50%	50%
<i>The following services are limited to 1 every 36 months.</i> D4240 - Gingival flap procedure, four or more teeth D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
<i>The following service is not subject to a frequency limit.</i> D4249 - Clinical crown lengthening - hard tissue	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.
<p><i>The following services are limited to 1 every 36 months.</i></p> <p>D4260 - Osseous surgery D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant D4263 - Bone replacement graft – first site in quadrant</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D4270 - Pedicle soft tissue graft procedure D4271 - Free soft tissue graft procedure</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D4273 - Subepithelial connective tissue graft procedures, per tooth D4275 - Soft tissue allograft D4277 - Free soft tissue graft - first tooth D4278 - Free soft tissue graft - additional teeth</p>	50%	50%
<p><i>The following services are limited to 1 time per quadrant every 24 months.</i></p> <p>D4341 - Periodontal scaling and root planning - four or more teeth per quadrant D4342 - Periodontal scaling and root planning - one to three teeth per quadrant</p>	50%	50%
<p><i>The following service is limited to a frequency to 1 per lifetime.</i></p> <p>D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis</p>	50%	50%
<p><i>The following service is limited to 4 times every 12 months in combination with prophylaxis.</i></p> <p>D4910 - Periodontal maintenance</p>	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
<p><i>The following services are limited to a frequency of 1 every 60 months.</i></p> <p>D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture -</p>	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.
mandibular D5211 - Mandibular partial denture - resin base D5212 - Maxillary partial denture - resin base D5213 - Maxillary partial denture - cast metal framework with resin denture base D5214 - Mandibular partial denture - cast metal framework with resin denture base D5281 - Removable unilateral partial denture - one piece cast metal		
<i>The following services are not subject to a frequency limit.</i> D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5510 - Repair broken complete denture base D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5620 - Repair cast framework D5630 - Repair or replace broken clasp D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture	50%	50%
<i>The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months.</i> D5710 - Rebase complete maxillary denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5730 - Reline complete maxillary denture D5731 - Reline complete mandibular denture D5740 - Reline maxillary partial denture D5741 - Reline mandibular partial	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.
denture D5750 - Reline complete maxillary denture (laboratory) D5751 - Reline complete mandibular denture (laboratory) D5752 - Reline complete mandibular denture (laboratory) D5760 - Reline maxillary partial denture (laboratory) D5761 - Reline mandibular partial denture (laboratory) - rebase/reline D5762 - Reline mandibular partial denture (laboratory)		
<i>The following services are not subject to a frequency limit.</i> D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
<i>The following services are not subject to a frequency limit.</i> D6210 - Pontic - case high noble metal D6211 - Pontic - case predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6245 - Pontic - porcelain/ceramic	50%	50%
<i>The following services are not subject to a frequency limit.</i> D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
<i>The following services are not subject to a frequency limit.</i> D6519 - Inlay/onlay - porcelain/ceramic D6520 - Inlay - metallic - two surfaces D6530 - Inlay - metallic - three or more surfaces D6543 - Onlay - metallic - three surfaces D6544 - Onlay - metallic - four or more surfaces	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.
<p><i>The following services are limited to 1 time every 60 months.</i></p> <p>D6740 - Crown - porcelain/ceramic D6750 - Crown - porcelain fused to high noble metal D6751 - Crown - porcelain fused to predominately base metal D6752 - Crown - porcelain fused to noble metal D6780 - Crown - 3/4 cast high noble metal D6781 - Crown - 3/4 cast predominately base metal D6782 - Crown - 3/4 cast noble metal D6783 - Crown - 3/4 porcelain/ceramic D6790 - Crown - full cast high noble metal D6791 - Crown - full cast predominately base metal D6792 - Crown - full cast noble metal</p>	50%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D6930 - Re-cement or re-bond fixed partial denture</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D6973 - Core build up for retainer, including any pins D6980 - Fixed partial denture repair necessitated by restorative material failure</p>	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D7140 - Extraction, erupted tooth or exposed root</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D7210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - complete bony with unusual surgical</p>	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.
complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal		
<i>The following service is not subject to a frequency limit.</i> D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
<i>The following service is not subject to a frequency limit.</i> D7280 - Surgical access of an unerupted tooth	50%	50%
<i>The following services are not subject to a frequency limit.</i> D7310 - Alveoplasty in conjunction with extractions - per quadrant D7311 - Alveoplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant D7320 - Alveoplasty not in conjunction with extractions - per quadrant D7321 - Alveoplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	50%	50%
<i>The following service is not subject to a frequency limit.</i> D7471 - removal of lateral exostosis (maxilla or mandible)	50%	50%
<i>The following services are not subject to a frequency limit.</i> D7510 - Incision and drainage of abscess D7910 - Suture of recent small wounds up to 5 cm D7921 - Collect - apply autologous product D7953 - Bone replacement graft for ridge preservation - per site D7971 - Excision of pericoronal gingiva	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
<i>The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit.</i>	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.
D9110 - Palliative (Emergency) treatment of dental pain - minor procedure		
<p><i>Covered only when clinically Necessary.</i></p> <p>D9220 - Deep sedation/general anesthesia first 30 minutes D9221 - Dental sedation/general anesthesia each additional 15 minutes D9241 - Intravenous conscious sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9610 - Therapeutic drug injection, by report</p>	50%	50%
<p><i>Covered only when clinically Necessary</i></p> <p>D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)</p>	50%	50%
<p><i>The following is limited to 1 guard every 12 months.</i></p> <p>D9940 - Occlusal guard</p>	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
<p><i>The following services are limited to 1 time every 60 months.</i></p> <p>D6010 - Endosteal implant D6012 - Surgical placement of interim implant body D6040 - Eposteal Implant D6050 - Transosteal implant, including hardware D6053 - Implant supported complete denture D6054 - Implant supported partial denture D6055 - Connecting bar implant or abutment supported D6056 - Prefabricated abutment D6057 - Custom abutment D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to high noble metal D6060 - Abutment supported porcelain fused to predominately base metal crown D6061 - Abutment supported porcelain fused to noble metal crown D6062 - Abutment supported cast high</p>	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.
<p>noble metal crown D6063 - Abutment supported case predominately base metal crown D6064 - Abutment supported porcelain/ceramic crown D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported porcelain fused to high metal crown D6067 - Implant supported metal crown D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture D6072 - Abutment supported retainer for cast high noble metal fixed partial denture D6073 - Abutment supported retainer for predominately base metal fixed partial denture D6074 - Abutment supported retainer for cast metal fixed partial denture D6075 - Implant supported retainer for ceramic fixed partial denture D6076 - Implant supported retainer for porcelain fused to high noble metal fixed partial denture D6077 - Implant supported retainer for cast metal fixed partial denture D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch D6080 - Implant maintenance procedure D6090 - Repair implant prosthesis D6091 - Replacement of semi-precision or precision attachment D6095 - Repair implant abutment D6100 - Implant removal D6101 - Debridement periimplant defect D6102 - Debridement and osseous periimplant defect D6103 - Bone graft periimplant defect</p>		

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.
D6104 - Bone graft implant replacement D6190 - Implant index		
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
<p>Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically 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.</p> <p>All orthodontic treatment must be prior authorized.</p> <p>Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.</p>		
<p><i>The following services are not subject to a frequency limitation as long as benefits have been prior authorized.</i></p> <p>D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8050 - Interceptive orthodontic treatment of the primary dentition D8060 - Interceptive orthodontic treatment of the transitional dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention</p>	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 Service 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 becoming enrolled for coverage provided through the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

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

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

If the Insured Person would like to use a claim form, call Customer Service at 1-844-255-8361. This number is also listed on the Insured's Dental ID Card. If the Insured Person does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

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

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.

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

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.

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

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

Necessary - Dental Services and supplies 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. The definition of Necessary 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.

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

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

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

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

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

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

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

Section 17: Pediatric Vision Services Benefit

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

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a 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 1-844-255-8361. 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.

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

Policy Deductible

Benefits for pediatric Vision Care Services provided 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

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.

Frequency of Service Limits

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

Routine Vision Examination

A routine vision examination of the 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 Person 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.

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.

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

Eyeglass Frames

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

The Insured Person is eligible to 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.

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

Contact Lenses

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

Benefits include the fitting/evaluation fees 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

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.		
<ul style="list-style-type: none"> • Single Vision 		100% after a Copayment of \$40.	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
• 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.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to \$130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - 160.		100% after a Copayment of \$15.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$160 - 200.		100% after a Copayment of \$30.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - 250.		100% after a Copayment of \$50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.		60%	50% of the billed charge.

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

Section 2: Pediatric Vision Exclusions

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

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Section 1: Benefits for 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. Information about claim timelines and responsibilities in the General Provisions section in the Certificate of Coverage applies to Vision Care Services provided, except that when the Insured Person submits a Vision Services claim, the Insured Person must provide the Company with all of the information identified below.

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services 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 from the ID card.
- 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

Section 4: Defined Terms for Pediatric Vision Care Services

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

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a 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*.

Schedule of Benefits

Missouri State University

2017-202864-4

METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 82.470%

Injury and Sickness Benefits

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

Deductible Preferred Provider	\$250 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network	\$500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80%
Coinsurance Out-of-Network	60%
Out-of-Pocket Maximum Preferred Provider	\$6,850 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	\$13,700 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network	\$13,700 (Per Insured Person, Per Policy Year)

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

The Preferred Provider for this plan is UnitedHealthcare 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.

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 Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Student Health Center Benefits: 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 of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider	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

Inpatient	Preferred Provider	Out-of-Network Provider
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing Payable within 7 working days prior to admission.	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous	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 Copay 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 Chiropractic Care.	Preferred Allowance \$10 Copay per visit	Usual and Customary Charges \$10 Copay per visit
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	Preferred Allowance \$100 Copay per visit	Usual and Customary Charges \$100 Copay 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 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	HealthSmart Rx Pharmacies \$25 Copay per prescription for generic drugs \$50 Copay per prescription for preferred brand drugs \$60 Copay per prescription for non-preferred brand drugs 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.	Out-of-Network Pharmacies \$50 Copay per prescription for generic drugs \$70 Copay per prescription for brand name Up to a 31 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 Copay 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 Device and Reconstructive Breast 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
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
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

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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



President

In consideration of the premium charged, it is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

Benefits for the Treatment of Speech and Hearing Disorders

Benefits will be paid the same as any other Sickness for the necessary care and treatment of Loss or Impairment of Speech or Hearing.

"Loss or impairment of speech or hearing" means those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which fall within the scope of his or her license or certification.

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

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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



President

In consideration of the premium charged, it is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

Benefits for Child Health Supervision Services

Benefits will be paid the same as any other Sickness for Child Health Supervision Services. Such services will be paid from the moment of birth through the age of twelve years at approximately the following age intervals: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, and twelve years.

Benefits for Child Health Supervision Services which are rendered during a periodic review will be limited to Covered Medical Expenses provided by or under the supervision of a single Physician during the course of one visit.

"Child health supervision services" means the periodic review of a child's physical and emotional status by a Physician or pursuant to a Physician's supervision. A review shall include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

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

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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



President

In consideration of the premium charged, it is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

Benefits for Breast Cancer Treatment

Benefits will be paid the same as any other Sickness for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

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