

UNITEDHEALTHCARE INSURANCE COMPANY
BLANKET STUDENT INJURY AND SICKNESS INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of



**UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES**

2018-2019

This Certificate of Coverage is Part of Policy # 2018-5338-1

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 1-800-767-0700, 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 1-800-767-0700. 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.

All students enrolled at UAMS are required to purchase this insurance plan at registration, unless proof of comparable coverage is furnished.

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., August 10, 2018. 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, 2019. 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 Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

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

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

Section 4: Pre-Admission Notification

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

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

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

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

Section 5: Preferred Provider 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 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

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

“Network Area” means the 30 mile radius around the Named Insured's residence.

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 (800) 767-0700 for information about Preferred Hospitals.

Out-of-Network Providers - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare 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.

Continuity of Care

The Company will allow a newly enrolled Insured to continue to receive Covered Medical Expenses rendered by an out-of-network provider at the time of the Insured Person's transition to coverage under the Policy from another carrier's policy until the current episode of treatment ends or until the end of ninety (90) days, whichever occurs first.

In the event a contract or agreement between the Company and health care provider is terminated, an Insured under this plan may continue to receive care from that provider as an in-network benefit until a current episode of treatment for an acute condition is completed or until the end of ninety (90) days, whichever occurs first.

The Insured Person may call (800) 767-0700 for information on how request to continue services.

The provider shall be deemed to be a participating provider for purposes of reimbursement, utilization management, and quality of care.

Section 6: 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.**

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

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

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

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

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 as defined in the Policy):

- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. Other than as provided for Habilitative Services or in Benefits for the Treatment of Speech and Hearing Disorders, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.

Benefits will be subject to the same Deductible, Copay and Coinsurance amounts as Outpatient Physician's Visits.

17. **Medical Emergency Expenses.**

Only in connection with a Medical Emergency as defined. Benefits will be paid for:

- The facility charge for use of the emergency room and supplies.

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

18. **Diagnostic X-ray Services.**

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.

Benefits include services and treatment related to inotropic agents for congestive heart failure and trans-telephonic home spirometry.

22. Injections.

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

23. Chemotherapy.

See Schedule of Benefits.

24. Prescription Drugs.

See Schedule of Benefits.

Other

25. Ambulance Services.

See Schedule of Benefits. Benefits include ground, air or water ambulance service to the nearest Hospital.

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.

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.

Benefits for Durable Medical Equipment include all of the following:

- Braces used to stabilize an injured body part and braces that treat curvature of the spine.
- Eye prosthesis and polishing services for eye prosthesis.
- Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve Injury when pain is unresponsive to medication.
- High frequency chest wall oscillators for Insureds with cystic fibrosis.

See also Benefits for Orthotic and 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.
- Orthodontic services for the stabilization and re-alignment of the Injury involved teeth to pre-Injury position.

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

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

29. **Mental Illness Treatment.**

Benefits will be paid for services received:

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

The following services are included for the treatment of Mental Illness:

- Diagnostic evaluation.
- Crisis intervention and stabilization for acute episodes.
- Treatment and counseling (including individual or group therapy visits).
- Professional charges for intensive outpatient treatment in a provider's office or other professional setting.
- Electroconvulsive therapy.
- Medication evaluation and management (pharmacotherapy).

30. **Substance Use Disorder Treatment.**

Benefits will be paid for services received:

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

The following services are included for the treatment of Mental Illness:

- Diagnostic evaluation.
- Crisis intervention and stabilization for acute episodes.
- Treatment and counseling (including individual or group therapy visits).
- Professional charges for intensive outpatient treatment in a provider's office or other professional setting.
- Electroconvulsive therapy.
- Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling.
- Medication evaluation and management (pharmacotherapy).

31. **Maternity.**

Same as any other Sickness.

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

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

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

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 Mastectomy and Reconstructive Breast Surgery.

35. **Diabetes Services.**

Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes.

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 include services and treatment related to inotropic agents for congestive heart failure and trans-telephonic home spirometry.

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

37. **Hospice Care.**

Same as any other Sickness for an Insured Person that is terminally ill with a life expectancy of six months or less.

See Benefits for Hospice Care

38. **Inpatient Rehabilitation Facility.**

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

39. **Skilled Nursing Facility.**

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

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

40. **Urgent Care Center.**

Benefits are limited to:

- 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.

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 endorsements.

45. Complications of Smallpox Vaccine.

Benefits will be paid for complications resulting from the smallpox vaccination on the same basis as any other Sickness.

46. Genetic Testing.

Benefits for genetic testing are limited to: 1) amniocentesis to determine the presence of a disease, condition, or congenital anomaly in the fetus; and 2) symptomatic Insured's blood or tissue to determine if the Insured Person has a specific disease or condition only when:

- The genetic test is ordered by a Physician and is determined to be Medically Necessary.
- The genetic test is the only way to diagnose the disease or condition.
- The genetic test has been scientifically proven to improve outcomes when used to direct treatment.
- The genetic test will affect the Insured's treatment plan.

Benefits are also limited for genetic testing to determine the anticipated response to a particular pharmaceutical only when:

- The genetic test is ordered by a Physician and is determined to be Medically Necessary.
- The genetic test has been scientifically proven to improve outcomes when used to direct treatment.
- The genetic test will affect the Insured's treatment plan.

47. 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.

48. Vision Correction.

Benefits will be paid the same as any other Sickness for vision correction services, vision therapy developmental testing, and prescribed eyeglasses or contact lenses when required as a result of cataract surgery or covered Injury.

Benefits include:

- One pair of eyeglasses or contact lenses within six months following cataract surgery. Tinting or anti-reflective coating and progressive lenses are not covered.
- Orthoptic and pleoptic training with continuing medical direction and evaluation.
- Sensorimotor examination.
- Developmental testing.

Section 7: Mandated Benefits

BENEFITS FOR DRUGS FOR TREATMENT OF CANCER

Benefits will be paid the same as any other Prescription Drug for any drug approved by the United States Food and Drug Administration (F.D.A.) for use in the treatment of cancer that has not been approved by the United States FDA for the treatment of the specific type of cancer for which the drug has been prescribed if the drug meets any of the following:

1. The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more of these standard reference compendia:
 - a. The American Hospital Formulary Service Drug Information.
 - b. The National Comprehensive Cancer Network Drugs and Biologics Compendium.
 - c. The Elsevier Gold Standard's Clinical Pharmacology.
2. The drug has been recognized as safe and effective for treatment of that specific type of cancer in two articles from Medical Literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from Medical Literature.
3. Other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the Commissioner.

Coverage of such drugs includes all services that are a Medical Necessity associated with the administration of the drug, provided such services are covered by the Policy.

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

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

"Medical literature" means articles from major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 107 Stat. 591 (1993), 42 U.S.C. § 1395x(t)(2)(B), as amended.

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

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for the treatment of diabetes mellitus, including but not limited to Type I, Type II, and gestational diabetes, for medically appropriate and necessary equipment and supplies, including podiatric appliances when prescribed by a Physician. Benefits will include training programs for Diabetes Self-Management Training and educational services used to treat diabetes, when determined by the Insured's treating Physician to be Medically Necessary and when provided by an appropriately licensed health care professional. Diabetes Self-Management Training, educational services and nutrition counseling must be provided under the direct supervision of a Physician.

"Diabetes self-management training" means instruction in an inpatient or outpatient setting. This includes medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic

therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

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

BENEFITS FOR MASTECTOMY AND RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid the same as any other Sickness for mastectomy and reconstructive breast surgery following a mastectomy on one or both breasts to produce a symmetrical appearance including coverage of prostheses and physical complications of mastectomy, including lymphedemas.

Mastectomy benefits shall provide for medical and surgical benefits for any hospital stay in connection with a mastectomy for not less than forty-eight hours unless the decision to discharge the patient before the expiration of the minimum length of stay is made by an attending physician in consultation with the Insured Person.

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

BENEFITS FOR IN VITRO FERTILIZATION

Benefits will be paid the same as any other Sickness for in vitro fertilization procedures performed at medical facilities licensed or certified by the Arkansas Department of Health as an in vitro fertilization clinic. If no such facility is licensed or certified in this State or no such licensing program is operational, then coverage shall be extended for any procedures performed at a facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Benefits will be paid for in vitro fertilization services to the same extent as the benefits provided for other pregnancy-related procedures provided that:

1. The patient is the Named Insured or the spouse of the Named Insured and a covered Dependent under the Policy.
2. The patient's oocytes are fertilized with the sperm of the patient's spouse.
3. The patient and the patient's spouse have a history of unexplained infertility of at least (2) two years duration; or
4. The infertility is associated with one or more of the following medical conditions:
 - a. Endometriosis.
 - b. Exposure in utero to Diethylstilbestrol, commonly known as DES; or
 - c. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy).
5. The patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the Policy.

Cryopreservation, the procedure whereby embryos are frozen for later implantation, shall be included as an in vitro fertilization procedure.

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

BENEFITS FOR CHILDREN'S PREVENTIVE HEALTH CARE SERVICES

Benefits will be provided for Periodic Preventive Care Visits for covered Dependent children from the moment of birth through the age of eighteen (18) as specified below.

Benefits for Children's Preventive Health Care Services will include twenty (20) visits at approximately the following age intervals: birth, two (2) weeks, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4) years, five (5) years, six (6) years, eight (8) years, ten (10) years, twelve (12) years, fourteen (14) years, sixteen (16) years, and eighteen (18) years. Benefits will be provided only to the extent that these services are provided by or under the supervision of a single Physician during the course of one (1) visit.

Benefits will be reimbursed at levels established by the Arkansas Insurance Commissioner.

"Children's preventive health care services" means Physician-delivered or Physician-supervised services for covered Dependents from birth through age eighteen (18) for Periodic Preventive Care Visits including medical history, physical

examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

"Periodic preventive care visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

Benefits for the recommended immunization services will be exempt from any copayment, coinsurance, Deductible or dollar limitation provisions in the Policy. All other Children's Preventive Health Care Services will be subject to all Copayment, Coinsurance, and Deductible or dollar limitation provisions in the Policy.

BENEFITS FOR MEDICAL FOODS AND FORMULAS

Benefits will be paid the same as any other Sickness for Medical Food products and formulas used for the treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas. Benefits include, without limitation, the following Medical Food products and formulas:

1. Low Protein Modified Food Products.
2. Amino-acid-based elemental formulas.
3. Extensively hydrolyzed protein formulas.
4. Formulas with modified vitamin or mineral content.
5. Modified nutrient content formulas.

Benefits for Medical Food products and formulas must be either of the following:

1. Prescribed as Medically Necessary by a healthcare provider.
2. A healthcare provider must issue a written order stating the Medical Food or Low Protein Modified Food Product is Medically Necessary for the therapeutic treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas.

The Medical Food product or formula must be administered under the direction of the Arkansas licensed Physician and under the direction of a clinical geneticist and registered dietitian. The treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas must be derived from evidence-based practice guidelines and efficacious.

Benefits for Medical Food will be covered regardless of the following:

1. Delivery method, whether enteral or oral.
2. Whether the Medical Food is used as a sole source or is supplemental.
3. The age of the Insured Person.

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry.

"Low protein modified food product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease.

"Medical disorder requiring specialized nutrients or formulas" means the following Inherited Metabolic Disease involving a failure to properly metabolize certain nutrients:

1. Nitrogen metabolism disorder.
2. Phenylketonuria.
3. Maple syrup urine disease.
4. Homocystinuria.
5. Citrullinemia.
6. Argininosuccinic academia.
7. Tyrosinemia, type 1.
8. Very-long-chain acyl-CoA dehydrogenase deficiency.
9. Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency.
10. Trifunctional protein deficiency.
11. Glutaric acidemia, type 1.
12. 3-methylcrotonyl CoA carboxylase deficiency.

13. Propionic academia.
14. Methylmalonic acidemia due to mutase deficiency.
15. Methylmalonic acidemia due to cobalamin A,B defect.
16. Isovaleric academia.
17. Ornithine transcarbamylase deficiency.
18. Non-ketotic hyperglycinemia.
19. Glycogen storage diseases.
20. Disorders of creatine metabolism.
21. Malonic aciduria.
22. Carnitine palmitoyl transferase deficiency type II.
23. Glutaric aciduria type II.
24. Sulfite oxidase deficiency.

"Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

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

BENEFITS FOR TREATMENT OF SPEECH AND HEARING DISORDERS

Benefits will be paid the same as any other Sickness for the necessary care and treatment of Loss or Impairment of Speech or Hearing subject to all terms and conditions of the Policy.

The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology, and which fall within the scope of his or her area of certification.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a Hospital or ambulatory surgical facility, if the Physician treating the patient certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Insured is:

1. A child under seven years of age who is determined by two dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment in a Hospital or ambulatory surgical center for a significantly complex dental condition.
2. A person with a diagnosed serious mental or physical condition; or
3. A person with a significant behavioral problem as determined by the covered person's physician as licensed under the Arkansas Medical Practices Act.

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening performed by a qualified medical professional.

Benefits include at least one screening per Policy Year for any male Insured Person forty (40) years of age or older in accordance with the National Comprehensive Cancer Network guidelines.

If a Physician recommends that an Insured Person undergo a Prostate Specific Antigen (PSA) blood test, benefits may not be denied on the ground that the Insured Person has already had a digital rectal examination and the examination was negative.

This benefit is not subject to the Policy Deductible and will not reduce or limit any other diagnostic benefits otherwise payable under the Policy. This benefit shall be subject to all other Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR ORTHOTIC AND PROSTHETIC DEVICES AND SERVICES

Benefits will be paid the same as any other Sickness but not less than eighty percent (80%) of the Medicare allowable rates for Orthotic and Prosthetic Devices and Services when such devices and services are: (1) prescribed by a licensed doctor of medicine, doctor of osteopathy, doctor of podiatric medicine; and (2) provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

Benefits include replacement of an Orthotic or Prosthetic device and related services, but not more frequently than one (1) time every three (3) years, unless Medically Necessary or necessitated by anatomical change or normal use.

"Orthotic device" means an external device that is: a.) Intended to restore physiological function or cosmesis to a patient; and b) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

"Orthotic device" does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: a) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and b) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body;

"Orthotic service" means the evaluation and treatment of a condition that requires the use of an orthotic device.

"Prosthetic device" means an external device that is: a) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and b) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

"Prosthetic device" does not include an artificial eye, an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body;

"Prosthetic service" means the evaluation and treatment of a condition that requires the use of a prosthetic device;

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

BENEFITS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

Benefits will be paid the same as any other Sickness for the Treatment of Autism Spectrum Disorder.

"Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders" including:

1. Autistic disorder.
2. Asperger's disorder.
3. Pervasive developmental disorder not otherwise specified.

Treatment includes:

1. The following care prescribed, provided, or ordered for a specific individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be Medically Necessary and evidence-based including without limitation:
 - a. Applied behavior analysis when provided by or supervised by a Board Certified Behavior Analyst.
 - b. Pharmacy care.
 - c. Psychiatric care.
 - d. Psychological care.
 - e. Therapeutic Care.
 - f. Equipment determined necessary to provide evidence-based treatment; and
2. Any care for an individual with Autism Spectrum Disorder that is determined by a licensed Physician to be:

- a. Medically Necessary; and
- b. Evidence-based.

“Autism service provider” means a person, entity, or group that provides diagnostic evaluations and treatment of autism spectrum disorders, including licensed Physicians, licensed psychiatrists, licensed speech therapists, licensed occupational therapists, licensed physical therapists, licensed psychologists, and broad-certified behavior analysts.

“Therapeutic care” means services provided by licensed speech therapists, occupational therapists, or physical therapist.

Benefits shall not be subject to any limits on the number of visits an Insured may make to an Autism Service Provider.

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

BENEFITS FOR GASTRIC PACEMAKER

Benefits will be paid the same as any other Sickness for a Gastric Pacemaker and shall be based on Medical Necessity.

Gastric Pacemaker means a medical device that:

1. Uses an external programmer and implanted electrical leads to the stomach; and
2. Transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat Gastroparesis.

“Gastroparesis” means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

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

BENEFITS FOR HOSPICE CARE

Benefits will be paid the same as any other Sickness for Hospice Care for terminally ill Insureds.

Such services must be provided by a Hospital, related institution, home health agency, hospice or other licensed facility under a Hospice Care program. Such services must be a part of a Hospice Care Program for:

1. Inpatient care services.
2. Physician services; or
3. Home hospice care services.

Benefits are not payable for expense incurred on or after an Insured's Medicare Eligibility Date.

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

BENEFITS FOR RECONSTRUCTIVE SURGERY OF A CRANIOFACIAL ANOMALY

Benefits will be paid the same as any other Sickness for reconstructive surgery and related medical care for an Insured Person of any age who is diagnosed as having a Craniofacial Anomaly if the surgery and treatment are Medically Necessary to improve a functional impairment that results from the Craniofacial Anomaly as determined by a nationally approved cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina.

The nationally approved cleft-craniofacial team shall: 1) evaluate a person with a craniofacial anomaly; and 2) coordinate a treatment plan for the Insured.

Benefits include Reconstructive Surgery, dental care, vision care and the use of at least one hearing aid.

“Craniofacial anomaly” means a congenital or acquired musculoskeletal disorder that primarily affects the cranial facial tissue.

“Reconstructive surgery” means the use of surgery to alter the form and function of the cranial facial tissues due to a congenital or acquired musculoskeletal disorder.

Any denial or limitation of coverage that is based on the lack of Medical Necessity to improve a functional impairment shall be referred for an external review.

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 Screening Mammography and Breast Ultrasound for the diagnosis of breast disease such as cancer and the evaluation of dense breast.

Benefits will be paid according to the following guidelines:

1. A baseline mammogram for an Insured Person who is thirty-five (35) to forty (40) years of age.
2. A mammogram for an Insured Person who is forty (40) years of age or older every year.
3. Upon recommendation of an Insured's Physician, without regard to age, where such Insured has had a prior history of breast cancer or where such Insured's mother or sister has had a history of breast cancer, positive genetic testing, or other risk factors; and
4. A comprehensive breast ultrasound of an entire breast or breasts if a mammogram screening demonstrates heterogeneously dense or extremely dense breast tissue when the Insured Person's Physician determines a comprehensive ultrasound screening is Medically Necessary.

Benefits for Screening Mammograms, including digital breast tomosynthesis, and Breast Ultrasounds will not reduce benefits payable for Diagnostic Mammograms or Breast Ultrasounds when recommended by the Insured's Physician.

"Breast ultrasound" means an imaging technique that uses harmless, high-frequency sound waves to produce detailed images of the breast in order to screen for and diagnose breast disease, such as cancer.

"Diagnostic mammography" means a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology usually characterized by the following medical events:

1. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities.
2. All images are reviewed by the Physician interpreting the study, and additional views are obtained as needed.
3. A physical examination of the breast by the interpreting Physician to correlate the radiologic findings is performed as part of the study when indicated.

"Mammography" means radiography of the breast.

"Screening mammography", including digital breast tomosynthesis, means a radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails at least two (2) views of each breast and includes a Physician's interpretation of the results of the procedure.

Benefits for Screening Mammography shall not be subject to a Deductible or Copayment and benefits for Breast Ultrasound shall not be subject to a Deductible.

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

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER TREATMENT

Benefits will be paid the same as any other Sickness for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures. Benefits shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Benefits shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a Physician or dentist.

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

BENEFITS FOR HEARING AIDS

Benefits will be paid for Hearing Aids or hearing instruments sold by a professional licensed by the state to dispense Hearing Aids or hearing instruments. Benefits begin on the first day of coverage and are limited to one hearing aid per hearing impaired ear every 36 months per Policy Year.

"Hearing aid" means an instrument or device, including repair and replacement parts, that: a) is designed and offered for the purpose of aiding Insured Persons with or compensating for impaired hearing; b) is worn in or on the body; and c) is generally not useful to an Insured Person in the absence of a hearing impairment.

Benefits shall not be subject to the Deductible and Copayments. All other Coinsurance, limitations, or any other provisions of the Policy shall apply.

BENEFITS FOR TELEMEDICINE SERVICES

Benefits will be paid for Telemedicine services on the same basis as services provided through an in person consultation between the Insured Person and a Physician. Benefits will include a reasonable facility fee to an Originating Site operated by a healthcare professional or a licensed healthcare entity if the healthcare professional or licensed healthcare entity is authorized to bill the Company directly for healthcare services.

"Telemedicine" means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of an Insured Person. Telemedicine includes Store-and-Forward Technology and Remote Patient Monitoring.

"Distant site" means the location of the healthcare professional delivering services through Telemedicine at the time the services are provided.

"Originating site" means a site at which an Insured Person is located at the time healthcare services are provided to him or her by means of Telemedicine.

"Remote patient monitoring" means the use of synchronous or asynchronous electronic information and communication technology to collect personal health information and medical data from an Insured Person patient at an Originating Site that is transmitted to a healthcare professional at a Distant Site for use in the treatment and management of medical conditions that require frequent monitoring.

"Store-and-forward technology" means the asynchronous transmission of an Insured Person's medical information from a healthcare professional at an Originating Site to a healthcare professional at the Distant Site.

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

BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

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

"Anticancer medication" means any drug or biologic that is used to kill, slow, or prevent the growth of cancerous cells.

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

Section 8: Coordination of Benefits Provision

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

Definitions

1. **Allowable Expenses:** Any health care expense, including Coinsurance, or Copays and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health Plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health Plan's deductible is not an allowable expense,

except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.

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

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

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

Plan includes all of the following:

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

Plan does not include any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this provision, We may recover such excess payments.

Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

Section 9: Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student policy for at least 6 consecutive months and who no longer meet the eligibility requirements under that policy are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

Application must be made and premium must be paid directly to UnitedHealthcare **StudentResources** and be received within 14 days after the expiration date of the Insured's coverage. For further information on the Continuation Privilege, please contact UnitedHealthcare **StudentResources**.

Section 10: Definitions

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.

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.

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

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

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).

Dependent shall also include any minor under the charge, care and control of the Named Insured that the Insured has filed a petition to adopt. Coverage shall begin:

1. On the date of the filing of the petition for adoption, provided the Named Insured applies within sixty (60) days after the filing of the petition for adoption; or
2. From the moment of birth, provided the petition for adoption and application for coverage is filed within (60) days after the birth of the minor.

Coverage shall terminate upon the dismissal or denial of a petition for adoption.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States. Elective surgery or elective treatment does not include new interventions (one that is not commonly recognized as accepted or standard treatment or which has not gained widespread, substantially unchallenged use and acceptance throughout the United States) that are deemed effective for the purposes of Medical Necessity when there is scientific evidence showing the intervention will achieve its intended purposes and will prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the Insured to risks that outweigh the potential benefits.

EMERGENCY SERVICES means with respect to a Medical Emergency:

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

HABILITATIVE SERVICES means health care services that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy, developmental services for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder, 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, vocational training and residential treatment are not habilitative services.

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

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

INJURY means bodily injury which is all of the following:

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

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other

bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to the Policy's Effective Date will be considered a Sickness under the Policy.

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

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

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

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

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

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

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

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

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

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

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

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

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *International Classification of Diseases Manual* and the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *International Classification of Diseases Manual*

and the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all mental health or psychiatric diagnoses are considered one Sickness.

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

NEWBORN INFANT means any child born of an Insured while that person is insured under the Policy. Newborn Infants will be covered under the Policy for the first 90 days after birth. Coverage for such a child will be for Injury or Sickness, including congenital defects, premature birth and tests for hypothyroidism, phenylketonuria and galactosemia, sickle-cell anemia, and all other genetic disorders for which screening is performed by or for the state of Arkansas as well as any testing of Newborn Infants hereafter mandated by law and shall also include coverage to pay for routine nursery care and pediatric charges for a well Newborn Infant for up to five (5) full days in a hospital nursery, or until the mother is discharged from the hospital following the birth of the child, whichever is less.

The Insured will have the right to continue such coverage for the child beyond the first 90 days. To continue the coverage the Insured must, within the 90 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 90 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 *International Classification of Diseases Manual* and the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *International Classification of Diseases Manual* and the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.

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

USUAL AND CUSTOMARY CHARGES means the 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. 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. Addiction, such as:
 - Caffeine addiction.
 - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
 - Codependency.
3. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation, except for Habilitative Services specifically provided in the Policy. Learning disabilities. Milieu therapy. Parent-child problems.
4. Biofeedback.
5. Cosmetic procedures, except reconstructive procedures to:
 - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
 - Treat or correct hemangiomas and port-wine stains for an Insured Person who is 12 years or younger.This exclusion does not apply to Benefits for Corrective Surgery of a Craniofacial Anomaly.
6. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
7. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 - As described under Dental Treatment in the Policy.This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Elective abortion.
10. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
11. 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.

12. Health spa or similar facilities. Strengthening programs.

13. 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 or as specified in Benefits for the Treatment of Speech and Hearing Disorders.
- A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
- Hearing aids as specifically provided in Benefits for Corrective Surgery of a Craniofacial Anomaly or in the Benefits for Hearing Aids.

14. Hirsutism. Alopecia.

15. Hypnosis.

16. 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.

17. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.

18. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.

19. 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.

20. Investigational services.

21. Lipectomy.

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

23. 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.

24. Reproductive/Infertility services including but not limited to the following:

- Genetic counseling and genetic testing.
- Cryopreservation of reproductive materials, except as specifically provided in the Benefits for In Vitro Fertilization. Storage of reproductive materials.
- Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except as specifically provided in the Benefits for In Vitro Fertilization.
- Premarital examinations.
- Impotence, organic or otherwise.
- Reversal of sterilization procedures.

25. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.

26. 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 benefits specifically provided in the Policy.
27. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
 28. 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.
 29. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. 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.
 30. Speech therapy, except as specifically provided in the Policy and in the Benefits for Treatment of Speech and Hearing Disorders. Naturopathic services.
 31. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
 32. Supplies, except as specifically provided in the Policy.
 33. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
 34. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
 35. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
 36. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid 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 for treatment, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

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

Section 13: General Provisions

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.

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 immediately upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

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. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

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.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

In the event that the Insured recovers from the third party, reasonable cost of collection and attorney's fees thereof shall be assessed against the Company and the Insured in the proportion each benefits from the recovery. In the event more than one casualty insurer, health insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement or hospital or medical services corporation having contractual subrogation rights are entitled to the subrogation benefits, reasonable cost of collection and attorney's fees thereof shall be assessed against the insurers and the Insured in the proportion each benefits from the recovery.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

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

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.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The provider's name;
5. The reason the claim should be reconsidered; and

6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Internal Appeal Process

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

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

Within 3 working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

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

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

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

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

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

1. For a Prospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 60 days after the Company's receipt of the grievance.

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

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

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

- f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
3. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
4. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
5. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

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

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

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

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

Expedited Internal Review Process

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

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

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Authorized Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

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

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

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

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

RIGHT TO EXTERNAL INDEPENDENT REVIEW

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

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Commissioner. Upon request of an External Review, the Commissioner shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

Where to Send External Review Requests

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

Arkansas Insurance Department, Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
855-332-2227
Insurance.consumer@arkansas.gov

Standard External Review (SER) Process

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

1. Within 5 business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. The Insured Person has exhausted the Company's Internal Appeal Process;
 - c. The Insured Person has provided all the information and forms necessary to process the request; and
 - d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
3. After receiving notice that a request is eligible for SER, the Commissioner shall, within 1 business day:
 - a. Assign an Independent Review Organization (IRO) from the Commissioner's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4.
 - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.

5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
 - b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
 - c. If the Company reverses its decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

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

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

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

2. Upon receipt of an EER request, the Commissioner shall immediately send a copy of the request to the Company.
3. Upon receipt of an EER request notice, the Company shall immediately complete a preliminary review to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
 - c. The Insured Person has provided all the information and forms necessary to process the request; and
 - d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
4. Immediately after completion of the review, the Company shall notify the Commissioner, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
5. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an Independent Review Organization (IRO) from the Commissioner's approved list and notify the Company of the name of the assigned IRO.
 - a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.

- b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
- 6. a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
- b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
- 7. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
 - a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
 - b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.
- 8. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Standard Experimental or Investigational Treatment External Review (SEIER) Process

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

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

- 1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Commissioner.
- 2. Upon receipt of an SEIER request, the Commissioner shall immediately send a copy of the request to the Company.
- 3. Within 5 business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
 - b. The recommended or requested health care services or treatment:
 - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - Standard health care services or treatments are not medically appropriate for the Insured Person;
 - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
 - d. The Insured Person's treating Physician:
 - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. The Insured Person has exhausted the Company's Internal Appeal Process; and
 - f. The Insured Person has provided all the information and forms necessary to process the request.
- 4. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or

- b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
5. After receiving notice that a request is eligible for SEIER, the Commissioner shall, within 1 business day:
 - a. Assign an IRO from the Commissioner's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
6.
 - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SEIER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
7. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
8. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
 - b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
9. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 20 calendar days after being selected by the IRO.
10. The IRO shall make a decision and provide oral or written notice of its decision within 20 days after receipt of the opinions from each clinical reviewer.
11. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational Treatment External Review (EEIER) Process

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

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

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

2. Upon receipt of an EEIER request, the Commissioner shall immediately send a copy of the request to the Company.

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

- b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
11. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 5 calendar days after being selected by the IRO.
 12. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
 13. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

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.

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

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

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

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

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

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

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include

ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

Questions Regarding Appeal Rights

Contact Customer Service at 1-800-767-0700 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

Arkansas Insurance Department, Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
855-332-2227
Insurance.consumers@arkansas.gov

Section 15: Online Access to Account Information

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

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

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

Section 16: ID Cards

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

Section 17: UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating healthcare or Mental Health providers, find contact information for the provider's office or facility, and locate the provider's office or facility on a map.
- Find My Claims – view claims received within the past 120 days for both the primary Insured and covered Dependents; includes provider, date of service, status, claim amount and amount paid.

Section 18: Important Company Contact Information

The Policy is Underwritten by:

UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare **StudentResources**
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700
Web site: www.uhcsr.com

Plan is arranged by:
Academic HealthPlans, Inc.
P.O. Box 1605
Colleyville, TX 76034-1605
1-855-824-9679
uams.myahpcare.com

Customer Service:

800-767-0700

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

Schedule of Benefits

University of Arkansas – For Medical Sciences

2018-5338-1

METALLIC LEVEL – SILVER WITH ACTUARIAL VALUE OF 75.150%

Injury and Sickness Benefits

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

Deductible Preferred Provider	\$1,000 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network	\$2,000 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	70% except as noted below
Coinsurance Out-of-Network	50% except as noted below
Out-of-Pocket Maximum Preferred Provider	\$5,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	\$10,000 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network	\$12,700 (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 a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. 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 for Covered Medical Expenses incurred when referred by the UAMS Student Health Clinic for the following services: X-ray and Laboratory services.

Copays: All Copays specified in the Schedule of Benefits are in addition to the Policy Deductible, except for Prescription Drugs.

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	Paid as any other Sickness	Paid as any other Sickness

Inpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	25% of surgery allowance	25% of surgery allowance
Anesthetist Services	25% of surgery allowance	25% of surgery allowance
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	25% of surgery allowance	25% of surgery allowance
Anesthetist Services	25% of surgery allowance	25% of surgery allowance
Physician's Visits	\$30 Copay per visit 100% of Preferred Allowance	\$30 Copay per visit 75% of Usual and Customary Charges
Physiotherapy Limits per Policy Year as follows: 30 visits of any combination of physical therapy, occupational therapy, and speech therapy 30 visits of manipulative therapy Separate physical, occupational, and speech therapy limits apply to rehabilitative and Habilitative Services. See also Benefits for Treatment of Speech and Hearing Disorders.	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	\$200 Copay per visit Preferred Allowance	\$200 Copay per visit 70% of Usual and Customary Charges
Diagnostic X-ray Services	\$50 Copay per visit 100% of Preferred Allowance	\$50 Copay per visit 75% of Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	\$50 Copay per visit 100% of Preferred Allowance	\$50 Copay per visit 75% of Usual and Customary Charges
Tests and Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	UnitedHealthcare Pharmacy (UHCP) \$15 Copay per prescription Tier 1 \$30 Copay per prescription Tier 2 \$60 Copay per prescription Tier 3 up to a 31-day supply per prescription \$100 Deductible (per Policy Year) When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge). Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90-day supply	Usual and Customary Charges up to a 31-day supply per prescription

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	Preferred Allowance	70% of Usual and Customary Charges
Durable Medical Equipment See also Benefits for Orthotic and Prosthetic Devices and Services.	Preferred Allowance	70% of Usual and Customary Charges
Consultant Physician Fees	Preferred Allowance	Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	80% of Preferred Allowance	80% of Usual and Customary Charges
Mental Illness Treatment	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment	Paid as any other Sickness	Paid as any other Sickness
Maternity	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	No Benefits	No Benefits
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	75% of Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy See Benefits for Mastectomy and Reconstructive Breast Surgery	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Preferred Allowance	Usual and Customary Charges
Hospice Care See Benefits for Hospice Care	Paid as any other Sickness	Paid as any other Sickness
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	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider	Out-of-Network Provider
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Complications of Smallpox Vaccine	Paid as any other Sickness	Paid as any other Sickness
Genetic Testing	Preferred Allowance	Usual and Customary Charges
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges
Vision Correction	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 of the terms and conditions of the Policy not inconsistent therewith.



President

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

Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and 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 877-816-3596 to determine which providers participate in the Network. The telephone number for *Customer Service* is also on the Insured's ID card.

Non-Network Benefits - 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 listed in this endorsement if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

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

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* of this endorsement.

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

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

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

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

When benefit limits apply, the limit stated refers to any combination of Network Benefits and 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.)		
<i>Evaluations (Checkup Exams)</i> <i>Limited to 2 times per 12 months.</i> Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D0150 - Comprehensive oral evaluation D0180 - Comprehensive periodontal evaluation <i>The following service is not subject to a frequency limit.</i> D0160 - Detailed and extensive oral evaluation - problem focused	50%	50%
<i>Intraoral Radiographs (X-ray)</i> <i>Limited to 2 series of films per 12 months.</i> D0210 - Complete series (including bitewings)	50%	50%
<i>The following services are not subject to a frequency limit.</i> D0220 - Intraoral - periapical first film D0230 - Intraoral - periapical - each additional film D0240 - Intraoral - occlusal film	50%	50%
<i>Any combination of the following services is limited to 2 series of films</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.
<i>per 12 months.</i> D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films D0277 - Vertical bitewings		
<i>Limited to 1 time per 36 months.</i> D0330 - Panoramic radiograph image	50%	50%
<i>The following services are not subject to a frequency limit.</i> D0340 - Cephalometric X-ray D0350 - Oral/Facial photographic images D0391 - Interpretation of diagnostic images D0470 - Diagnostic casts	50%	50%
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
<i>Dental Prophylaxis (Cleanings)</i> <i>The following services are limited to 2 times every 12 months.</i> D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	50%	50%
<i>Fluoride Treatments</i> <i>The following services are limited to 2 times every 12 months.</i> D1206 and D1208 - Fluoride	50%	50%
<i>Sealants (Protective Coating)</i> <i>The following services are limited to once per first or second permanent molar every 36 months.</i> D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	50%	50%
<i>Space Maintainers (Spacers)</i> <i>The following services are not subject to a frequency limit.</i> D1510 - Space maintainer - fixed - unilateral D1515 - Space maintainer - fixed - bilateral D1520 - Space maintainer - removable - unilateral D1525 Space maintainer - removable bilateral	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.
D1550 - Re-cementation of space maintainer		
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
<p><i>Amalgam Restorations (Silver Fillings)</i></p> <p>50%</p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent</p>	50%	50%
<p><i>Composite Resin Restorations (Tooth Colored Fillings)</i></p> <p>50%</p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior</p>	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
<p><i>The following services are subject to a limit of 1 time every 60 months.</i></p> <p>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 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</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>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%
<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%

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> D3222 - Partial pulpotomy for Apexogenesis - Permanent tooth with incomplete root development	50%	50%
<i>The following services are not subject to a frequency limit.</i> D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
<i>The following services are not subject to a frequency limit.</i> 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	50%	50%
<i>The following services are not subject to a frequency limit.</i> D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification - interim medication replacement D3353 - Apexification/recalcification - final visit	50%	50%
<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>	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.
D3450 - Root amputation - per root		
<i>The following service is not subject to a frequency limit.</i>	50%	50%
D3920 - Hemisection (including any root removal), not including root canal therapy		
Periodontics - (Subject to payment of the Dental Services Deductible.)		
<i>The following services are limited to a frequency of 1 every 36 months.</i>	50%	50%
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		
<i>The following services are limited to 1 every 36 months.</i>	50%	50%
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		
<i>The following service is not subject to a frequency limit.</i>	50%	50%
D4249 - Clinical crown lengthening - hard tissue		
<i>The following services are limited to 1 every 36 months.</i>	50%	50%
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		
<i>The following services are not subject to a frequency limit.</i>	50%	50%
D4270 - Pedicle soft tissue graft procedure D4271 - Free soft tissue graft procedure		
<i>The following services are not subject to a frequency limit.</i>	50%	50%
D4273 - Subepithelial connective tissue graft procedures, per tooth D4275 - Soft tissue allograft		

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.
D4277 - Free soft tissue graft - first tooth D4278 - Free soft tissue graft - additional teeth		
<i>The following services are limited to 1 time per quadrant every 24 months.</i> D4341 - Periodontal scaling and root planning - four or more teeth per quadrant D4342 - Periodontal scaling and root planning - one to three teeth per quadrant	50%	50%
<i>The following service is limited to a frequency to 1 per lifetime.</i> D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis	50%	50%
<i>The following service is limited to 4 times every 12 months in combination with prophylaxis.</i> D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
<i>The following services are limited to a frequency of 1 every 60 months.</i> D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - 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	50%	50%
<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 -	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 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		
<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 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/relined D5762 - Reline mandibular partial denture (laboratory)	50%	50%
<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>	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.
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		
<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%
<i>The following services are limited to 1 time every 60 months.</i> 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	50%	50%
<i>The following service is not subject to a frequency limit.</i> D6930 - Re-cement or re-bond fixed	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.
partial denture		
<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 complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal</p>	50%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</p>	50%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D7280 - Surgical access of an unerupted tooth</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D7310 - Alveoloplasty in conjunction with extractions - per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - per</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.
quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant		
<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> D9110 - Palliative (Emergency) treatment of dental pain - minor procedure	50%	50%
<i>Covered only when clinically Necessary.</i> 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	50%	50%
<i>Covered only when clinically Necessary</i> D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	50%	50%
<i>The following is limited to 1 guard every 12 months.</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.
D9940 - Occlusal guard		
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 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</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.
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 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>		
<i>The following services are not subject to a frequency limitation as long as benefits have been prior authorized.</i> D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition	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.
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		

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this endorsement in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, 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 this endorsement to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from 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:

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

If the Insured Person would like to use a claim form, call Customer Service at 1-877-816-3596. 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 endorsement.

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

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

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

Dental Services Deductible - the amount the Insured Person must pay for Covered Dental Services in a Policy Year before the Company will begin paying for Network or 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 under this endorsement which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

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

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

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

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.

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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



President

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

When obtaining these Vision Care Services from a 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 under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*. Any amount the Insured Person pays in Copayments for Vision Care Services under this endorsement applies to the Out-of-Pocket Maximum stated in the Policy *Schedule of Benefits*.

Policy Deductible

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

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

Low Vision

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

Benefits include:

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

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of \$20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of \$40.	50% of the billed charge..
• Bifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Trifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Lenticular		100% after a Copayment of \$40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate		100%	100% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
lenses			
<ul style="list-style-type: none"> Standard scratch-resistant coating 		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
<ul style="list-style-type: none"> Eyeglass frames with a retail cost up to \$130. 		100%	50% of the billed charge.
<ul style="list-style-type: none"> Eyeglass frames with a retail cost of \$130 - 160. 		100% after a Copayment of \$15.	50% of the billed charge.
<ul style="list-style-type: none"> Eyeglass frames with a retail cost of \$160 - 200. 		100% after a Copayment of \$30.	50% of the billed charge.
<ul style="list-style-type: none"> Eyeglass frames with a retail cost of \$200 - 250. 		100% after a Copayment of \$50.	50% of the billed charge.
<ul style="list-style-type: none"> Eyeglass frames with a retail cost greater than \$250. 		60%	50% of the billed charge.
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
<ul style="list-style-type: none"> Covered Contact Lens Selection 	Limited to a 12 month supply.	100% after a Copayment of \$40.	50% of the billed charge.
<ul style="list-style-type: none"> Necessary Contact Lenses 	Limited to a 12 month supply.	100% after a Copayment of \$40.	50% of the billed charge.
Low Vision Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
<ul style="list-style-type: none"> Low vision testing 		100% of the billed charge.	75% of the billed charge.
<ul style="list-style-type: none"> Low vision therapy 		100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services 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:

By mail:

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

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a 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 this endorsement in *Section 1: Benefits for Pediatric Vision Care Services*.

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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



President

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

UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

Benefits for Prescription Drug Products

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

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

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

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after $\frac{3}{4}$ of the original Prescription Drug Product has been used.

The Insured must present their ID card to the Network Pharmacy when the prescription is filled. If the Insured does not present their ID card to the Network Pharmacy, they will need to pay for the Prescription Drug and then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting www.uhcsr.com and logging in to their online account or by calling *Customer Service* at 1-855-828-7716.

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

When prescriptions are filled at pharmacies outside a Network Pharmacy, the Insured must pay for the Prescription Drugs out of pocket and submit the receipts for reimbursement as described in the How to File a Claim for Injury and Sickness Benefits section in the Certificate of Coverage.

Copayment and/or Coinsurance Amount

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

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

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

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

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

Supply Limits

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

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

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

Note: Some products are subject to additional supply limits based on criteria that the Company has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change, and therefore the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

Designated Pharmacies

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

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Pharmacy, the Insured may opt-out of the Designated Pharmacy program through the Internet at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716. If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, the Insured will be responsible for the entire cost of the Prescription Drug Product.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, no benefits will be paid for that Prescription Drug Product, or, for a Specialty Prescription Drug Product, if the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

If the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

Notification Requirements

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

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

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. There may be certain Prescription Drug Products that require the Insured to notify the Company directly rather than the Insured's Physician or pharmacist. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

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

When the Insured submits a claim on this basis, the Insured may pay more because they did not notify the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any Deductible that applies.

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

Limitation on Selection of Pharmacies

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

within 31 days of the date the Company notifies the Insured, the Company will select a single Network Pharmacy for the Insured.

Coverage Policies and Guidelines

The Company's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on its behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

The Company may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to the Insured.

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

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

Rebates and Other Payments

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

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

Definitions

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

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

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

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies,

medications, or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

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

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

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

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

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

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

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

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

- Inhalers.
- Insulin.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose monitors.

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

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

Prescription Drug List Management Committee means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

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

Preventive Care Medications means the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, or Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Insured may determine whether a drug is a Preventive Care Medication through the internet at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

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

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

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

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

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

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

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

Additional Exclusions

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

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

2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Company's PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided in Benefits for Phenylketonuria.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
11. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
12. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Durable medical equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
15. Diagnostic kits and products.
16. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Right to Request an Exclusion Exception

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

Urgent Requests

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

External Review

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

Expedited External Review

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

NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-260-2723。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-260-2723.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-260-2723.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-866-260-2723.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-260-2723.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-260-2723.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-260-2723.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-260-2723.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-260-2723 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-260-2723 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-260-2723 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-260-2723

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-260-2723។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'í. T'áá shoodí kohjì' 1-866-260-2723 hodíłnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.