

New York Student Health Plan
This is Your

**PREFERRED PROVIDER ORGANIZATION
CERTIFICATE OF COVERAGE**

Issued by
UnitedHealthcare Insurance Company of New York

This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Policy between UnitedHealthcare Insurance Company of New York (hereinafter referred to as “We”, “Us” or “Our”) and the Policyholder. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

You have the right to return this Certificate. Examine it carefully. If You are not satisfied, You may return this Certificate to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Certificate. We will refund any Premium paid including any Certificate fees or other charges.

This Certificate offers You the option to receive Covered Services on three benefit levels:

- 1. In-Network Preferred Benefits.** In-network preferred benefits are the highest level of coverage available. In-network preferred benefits apply when Your care is provided by Student Health Center network. You should always consider receiving health services first through Student Health Center.
- 2. In-Network Benefits.** In-network benefits are the intermediate level of coverage available. In-network benefits apply when Your care is provided by Student Health Center Participating Providers that are not and are in Our UnitedHealthcare Options PPO network, or Our affiliate’s Dental and Spectera Vision network and Participating Pharmacies in Our UHCP network. You should always consider receiving health care services first through Student Health Center and then from Participating Providers that are not Student Health Center.
- 3. Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider’s charge.

PLEASE NOTE:
**THIS DOCUMENT HAS
CHANGED. PLEASE SEE THE
BACK COVER FOR DETAILS**

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

This Certificate is governed by the laws of New York State.

A handwritten signature in black ink, appearing to read 'William Golden', with a stylized flourish at the end.

William Golden, President

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SECTION I

Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated. If your Non- Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by UnitedHealthcare Insurance Company of New York, including the Schedule of Benefits and any attached riders.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before

We begin to pay for a particular Covered Service.

Durable Medical Equipment (“DME”): Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. “To stabilize” is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene

Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);

- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider or to a Preferred Provider. The amount can vary by the type of Covered Service.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider or to a Preferred Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers or Preferred Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers or Preferred Providers. This limit never includes Your Premium or services We do not Cover.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Student for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated

as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Copayment: A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Out-of-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.uhcsr.com or upon Your request to Us. The list will be revised from time to time by Us. You will pay higher Cost-Sharing to see a Participating Provider as compared to a Preferred Provider, but less than if You received Covered Services from a Non-Participating Provider.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Policy; or any anniversary date thereafter, during which the Certificate is in effect.

Policy: The Policy issued by UnitedHealthcare Insurance Company of New York to the Policyholder.

Policyholder: The institution of higher education that has entered in to an agreement with Us.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Preferred Provider: A Provider who has a contract with Us to provide services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration (“FDA”) and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician (“PCP”): A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from the Student Health Center in order to arrange for additional care for a Member.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of all counties in the State of New York.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled

nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Student: The person to whom this Certificate is issued.

Student Health Center: Any organization, facility, or clinic, operated, maintained, or supported by the school which provides health care services to a Student and has received accreditation by either the Accreditation Association of Ambulatory Health Care (AAAHC) or the Joint Commission for the ambulatory health care provided within their student health services.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility that provides Urgent Care.

Us, We, Our: UnitedHealthcare Insurance Company of New York and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Certificate.

Your school (referred to as the “Policyholder”) has purchased a Policy from Us. We will provide the benefits described in this Certificate to covered Members of the school, that is, to a Student. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request;
- Call 800-767-0700; or
- Visit Our website at www.uhcsr.com.

D. Preferred Providers.

Some Participating Providers are also Preferred Providers. Certain services may be obtained from Preferred Providers. See the Schedule of Benefits section of this Certificate for coverage of Preferred Provider services.

E. The Role of Primary Care Physicians.

This Certificate does not have a gatekeeper, usually known as a Primary Care Physician (“PCP”). You do not need a written Referral from the Student Health Center before receiving care.

1. **Access to Providers and Changing Providers.** Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a UnitedHealthcare Options PPO Member, and explain the reason for Your visit. Have Your ID card available. The Provider’s office may ask You for Your Member ID number. When You go to the Provider’s office, bring Your ID card with You.

F. Out-of-Network Services.

We Cover the services of Non-Participating Providers. However, some services are only Covered when You go to a Participating Provider. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

G. Services Subject to Preauthorization.

Our Preauthorization is required before You receive certain Covered Services.

Your PCP is responsible for requesting Preauthorization for in-network services and You are responsible for requesting Preauthorization for the out-of-network services listed in the Schedule of Benefits section of this Certificate.

H. Preauthorization Procedure.

If You seek coverage for out-of-network services that require Preauthorization, You must call Us at 800-767-0700.

I. Failure to Seek Preauthorization.

If You fail to seek Our Preauthorization for benefits subject to this section, We will pay an amount of \$500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining cost for services. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

J. Medical Management.

The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

K. Medical Necessity.

We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally- recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

L. Protection from Surprise Bills.

1. A surprise bill is a bill You receive for Covered Services in the following circumstances:
 - For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
 - A participating Physician is unavailable at the time the health care services are performed;
 - A non-participating Physician performs services without Your knowledge;
 - or

- Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the Referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
 - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
 - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
 - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your In-Network Copayment, Coinsurance or Deductible if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your In-Network Copayment, Coinsurance or Deductible.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.uhcsr.com for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Our website and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity (IDRE) assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at dfs.ny.gov. The IDRE will determine whether Our payment or Provider's charge is reasonable within 30 days of receiving the dispute.

M. Delivery of Covered Services Using Telehealth.

If Your Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

N. Case Management.

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

O. Important Telephone Numbers and Addresses.

- CLAIMS
800-767-0700

(Submit claim forms to this address.)

Submit Medical claims to:
UnitedHealthcare **Student**Resources
P. O. Box 809025
Dallas, TX 75380-9025

SI.DRG@uhcsr.com
(Submit electronic medical claim forms to this e-mail address)

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

<https://nyrmo.optummessenger.com/public/opensubmit>

(Submit electronic pediatric dental claim forms to this e-mail address)

Submit Pediatric Vision claims to:

Claims Department

P. O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax): 214-733-6060

<https://nyrmo.optummessenger.com/public/opensubmit>

(Submit electronic pediatric vision claim forms to this e-mail address)

- ASSIGNMENT OF BENEFITS FORM

Submit Assignment of Benefit forms for surprise bills to:

UnitedHealthcare **StudentResources**

P. O. Box 809025

Dallas, TX 75380-9025

SI.DRG@uhcsr.com

(Submit electronic assignment of benefit forms for surprise bills to this e-mail address)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS

800-767-0700

Claim Appeals

UnitedHealthcare **StudentResources**

P. O. Box 809025

Dallas, TX 75380-9025

800-767-0700

- MEMBER SERVICES

800-767-0700

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

- OUR WEBSITE

www.uhcsr.com

SECTION III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit, if available.

B. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

C. New Members In a Course of Treatment.

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. There are different Deductibles for services provided by Preferred Providers and Participating Providers. The Deductibles for Preferred Providers and Participating Providers apply to Covered in-network Services.

You have a separate In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services does not apply toward Your In-Network Deductible. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**

Prescription Drug Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Prescription Drugs during each Plan Year before We provide coverage. Cost-Sharing for out-of-network services does not apply toward Your In-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Prescription Drug Deductible.**

B. Copayments.

Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.

Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. In-Network Out-of-Pocket Limit.

When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered in-network Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual In-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will

provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family In-Network Out-of-Pocket Limit in payment of In-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family. There are different Out-of-Pocket Limits for services provided by Preferred Providers and Participating Providers. The Out-of-Pocket Limits for Preferred Providers and Participating Providers apply to Covered in-network Services. In-network Cost-Sharing amounts to which an Out-of-Pocket Limit applies will accumulate toward both the Out-of-Pocket Limits for Preferred Providers and for Participating Providers.

Cost-Sharing for out-of-network services, except for Emergency Services does not apply toward Your In-Network Out-of-Pocket Limit.

E. Out-of-Network Out-of-Pocket Limit.

This Certificate has a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate for out-of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits, section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for the entire family. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward Your Out-of-Network Out-of-Pocket Limit.**

Cost-Sharing for in-network services does not apply toward Your Out-of-Network Out-of-Pocket Limit.

F. Your Additional Payments for Out-of-Network Benefits.

When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as "co- surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment.

G. Allowed Amount.

"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider.

Our payments to Participating Providers may include financial incentives to help improve the quality of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. Facilities.

For Facilities, the Allowed Amount will be the lesser of:

- The 80th percentile of the Fair Health rate.
- The Facility's charge.
- A rate based on information provided by a third party vendor, which may reflect the one (1) or more of the following factors:
 - The complexity or severity of treatment.

- Level of skill and experience required for the treatment.
- Comparable Facilities' fees and costs to deliver care.

2. For All Other Providers.

For all other Providers the Allowed Amount will be the lesser of:

- The 80th percentile of the Fair Health rate.
- The Provider's charge.
- A rate based on information provided by a third party vendor, which may reflect the one (1) or more of the following factors:
 - The complexity or severity of treatment.
 - Level of skill and experience required for the treatment.
 - Comparable Providers' fees and costs to deliver care.

The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at 800-767-0700 or visit Our website at www.uhcsr.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

We reserve the right to negotiate a lower rate with Non-Participating Providers. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, and the Provider has agreed to extend the rate to this Certificate, the rate the Provider has agreed to accept from the other insurer or HMO will apply.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V

Who is Covered

A. Who is Covered Under this Certificate.

You, the Student to whom this Certificate is issued, are covered under this Certificate.

B. Types of Coverage.

We offer the following types of coverage:

- **Individual.** If You selected individual coverage, then You are covered.

C. When Coverage Begins.

Coverage under this Certificate will begin as follows:

- If You, the Student, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Policyholder. Your Policyholder cannot impose waiting periods that exceed 90 days.
- If You, the Student, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Policyholder's next open enrollment period to enroll, except as provided below.

D. Special Enrollment Periods.

You can also enroll for coverage within 30 days of the loss of coverage in a health plan if coverage was terminated because You are no longer eligible for coverage under the other health plan due to:

1. Termination of employment;
2. Termination of the other health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated for You Coverage;
or
7. A Child no longer qualifies for coverage as a Child under the other health plan.

You can also enroll 30 days from exhaustion of Your COBRA or continuation coverage or if you become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and Premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is

received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You lose eligibility for Medicaid or Child Health Plus; or
2. You become eligible for Medicaid or Child Health Plus.

We must receive notice and Premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

SECTION VI

Preventive Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care.

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 800-767-0700 or visit Our website at www.uhcsr.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an “A” or “B” rating from USPSTF, and immunizations recommended by ACIP.

- A. Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.
- B. Adult Annual Physical Examinations.** We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

Examples of items or services with an “A” or “B” rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening and diabetes screening. A

complete list of the Covered preventive Services is available on Our website at www.uhcsr.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

C. Adult Immunizations. We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.uhcsr.com, or will be mailed to You upon request.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member’s Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

F. Family Planning and Reproductive Health Services. We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

G. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for Coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not

include all of the above services such as drugs and devices and when provided by a Participating Provider.

H. Screening for Prostate Cancer. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, when provided by a Participating Provider.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.

“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance. In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Services, which shall not be excessive or unreasonable.

We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

We Cover Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;

- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
 - The point of pick-up is inaccessible by land vehicle; or
 - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

SECTION VIII

Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Emergency Services.

We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an “**Emergency Condition**” to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

- 1. Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department.**

We do not Cover follow-up care or routine care provided in a Hospital emergency department.

- 2. Emergency Hospital Admissions.** We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital. Any inpatient Hospital services received from a non-participating Hospital after Your medical condition no longer prevents Your transfer to a participating Hospital will be Covered at the out-of-network Cost-Sharing.
- 3. Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the amount We have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge and will be at least the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare.

If a dispute involving a payment for physician services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount determined by the IDRE for the physician services.

You are responsible for any in-network Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. **Urgent Care is Covered in or out of Our Service Area.**

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.
2. **Out-of-Network.** We Cover Urgent Care from a non-participating Urgent Care Center.

SECTION IX

Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Acupuncture.

We Cover acupuncture services rendered by a Health Care Professional licensed to provide such services.

B. Advanced Imaging Services.

We Cover PET scans, MRI, nuclear medicine, and CAT scans.

C. Allergy Testing and Treatment.

We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

D. Ambulatory Surgical Center Services.

We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

E. Chemotherapy.

We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate.

F. Chiropractic Services.

We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

G. Clinical Trials.

We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An “approved clinical trial” means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

H. Dialysis.

We Cover dialysis treatments of an Acute or chronic kidney ailment.

I. Habilitation Services.

We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional’s office.

J. Home Health Care.

We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

K. Infertility Treatment.

We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Such Coverage is available as follows:

- 1. Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services.

Basic infertility services include:

- Initial evaluation;
- Semen analysis;
- Laboratory evaluation;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

- 2. Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

Comprehensive infertility services include:

- Ovulation induction and monitoring;
- Pelvic ultra sound;
- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

- 3. Exclusions and Limitations.** We do not Cover:

- In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs for an ovum donor or donor sperm;
- Sperm storage costs;

- Cryopreservation and storage of embryos;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

L. Infusion Therapy.

We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

M. Interruption of Pregnancy.

We Cover medically necessary abortions, including abortions in cases of rape, incest or fetal malformation. We Cover elective abortions for one (1) procedure per Member, per Plan Year.

N. Laboratory Procedures, Diagnostic Testing and Radiology Services.

We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

O. Maternity and Newborn Care.

We Cover services for maternity care provided by a Physician or nurse midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a nurse midwife to be Covered, the nurse midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a nurse midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy for the duration of breast feeding[from a Participating Provider.

P. Office Visits.

We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

Q. Outpatient Hospital Services.

We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

R. Preadmission Testing.

We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

S. Prescription Drugs for Use in the Office and Outpatient Facilities.

We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

T. Rehabilitation Services.

We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- The therapy is ordered by a Physician.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

U. Second Opinions.

- **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written Referral to a non-participating Specialist.
- **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.
- **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will approve Covered Services supported by a majority of the Providers reviewing Your case.

V. Surgical Services.

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

W. Oral Surgery.

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.

- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

X. Reconstructive Breast Surgery.

We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Y. Other Reconstructive and Corrective Surgery.

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Z. Transplants.

We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants.

All transplants must be prescribed by Your Specialist(s).

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION X

Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Autism Spectrum Disorder.

We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

- 1. Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- 2. Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop, or tablet computers. We Cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

- 3. Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis

when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

4. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.
5. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.
6. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.
7. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for Persons With Developmental Disabilities shall not affect Coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will

generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for Persons with Developmental Disabilities.

B. Diabetic Equipment, Supplies and Self-Management Education.

We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. Equipment and Supplies.

We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:

- Acetone reagent strips
- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Blood glucose kit
- Blood glucose strips (test or reagent)
- Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose reagent strips
- Glucose reagent tape
- Injection aides
- Injector (Busher) Automatic
- Insulin

- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

2. Self-Management Education.

Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or otherwise Medically Necessary.

C. Durable Medical Equipment and Braces.

We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover

the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. Braces.

We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. Hearing Aids.

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

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years.

Bone anchored hearing aids are Covered only if You have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Certificate. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

E. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

F. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

G. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only Covered under the Pediatric Vision Care section of this Certificate.

We do not Cover shoe inserts.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per Plan Year. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

SECTION XI

Inpatient Services

(for other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Hospital Services.

We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

B. Observation Services.

We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.

We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

D. Inpatient Stay for Maternity Care.

We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

E. Inpatient Stay for Mastectomy Care.

We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.

We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Habilitation Services.

We cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

H. Rehabilitation Services.

We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

I. Skilled Nursing Facility.

We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Certificate). We Cover up to 200 days per Plan Year for non-custodial care.

J. End of Life Care.

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

K. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services.

1. Inpatient Services. We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities.

We also Cover inpatient mental health care services related to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. Outpatient Services. We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or

psychologist; a licensed clinical social worker a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist; or a professional corporation or a university faculty practice corporation thereof.

3. Limitations/Terms of Coverage. We do not Cover:

- Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
- Services solely because they are ordered by a court.

B. Substance Use Services.

1. Inpatient Services. We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes Coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and Part 817; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. Outpatient Services. We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also

available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

We also Cover up to 20 outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION XIII

Prescription Drug Coverage

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.

We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription”;
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider’s scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn’s disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.

- Off-label cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may inquire if a specific drug is Covered under this Certificate by contacting Us at 1-855-828-7716.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail, mail order or designated pharmacy as ordered by an authorized Provider. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Certificate.

C. Benefit and Payment Information.

1. Cost-Sharing Expenses. You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail, mail order or designated pharmacy.

You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

2. Participating Pharmacies. For Prescription Drugs purchased at a retail, mail order or designated Participating Pharmacy, You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Participating Pharmacy's Drug Cost for the Prescription Drug.
(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

3. Non-Participating Pharmacies. If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.

4. Designated Pharmacies. If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have Coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Anemia, neutropenia, thrombocytopenia;
- Antihyperlipidemic;
- Cardiovascular;
- CNS agents;
- Cystic fibrosis;
- Endocrine disorders/neurologic disorders such as infantile spasms;
- Enzyme deficiencies/liposomal storage disorders;
- Gaucher's disease;
- Growth hormone;
- Hematologic;
- Hemophilia;

- Hepatitis B, Hepatitis C;
- HIV/AIDS;
- Immune deficiency;
- Immune modulator;
- Infertility;
- Inflammatory conditions;
- Iron overload;
- Multiple sclerosis;
- Neutropenia;
- Oncology;
- Osteoporosis;
- Parkinson's disease;
- Psoriasis;
- Pulmonary arterial hypertension;
- Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis);
- Transplant.

5. Mail Order. Certain Prescription Drugs may be ordered through Our mail order pharmacy. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You may be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.uhcsr.com or by calling 1-855-828-7716.

6. Tier Status. The tier status of a Prescription Drug may change periodically.

Changes will generally be quarterly, but no more than six (6) times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.uhcsr.com or by calling 1-855-828-7716.

7. When a Brand-Name Drug Becomes Available as a Generic Drug. When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned or the Brand-Name Drug will be removed from the Formulary and You no longer have benefits for that particular Brand-Name Drug. Please note, if You are taking a Brand-Name Drug that is being excluded due to a Generic Drug becoming available, you will receive advance written notice of the Brand-Name Drug exclusion. You may request a Formulary exception as outlined below and in the External Appeals section of this Certificate.

8. Formulary Exception Process. If a Prescription Drug is not on Our Formulary You, Your designee, or Your prescribing Health Care Professional may request a Formulary exception for clinically-appropriate Prescription Drug in writing, electronically, or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this Certificate. Visit Our website at www.uhcsr.com or call 1-855-828-7716 to find out more about this process.

Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 72 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 24 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of

Your current course of treatment using the non-Formulary Prescription Drug.

9. Supply Limits. Except for contraceptive drugs or devices, We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply.

You may have an initial three-month supply of a contraceptive drug or device dispensed to You. For subsequent dispensing of the same contraceptive drug or device, You may have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time. Contraceptive drugs and devices are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Pharmacy. For other contraceptive drugs and devices, for an initial three-month supply, You are responsible for up to three (3) Cost-Sharing amounts and You are responsible for up to nine (9) Cost-Sharing Amounts for the remaining supply of a 12 month prescription. For a subsequent 12 month dispensing of the same contraceptive drug or device, You are responsible for up to twelve (12) Cost-Sharing amounts.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two and a half (2.5); Cost-Sharing amounts for a 90-day supply.

Specialty Prescription Drugs may be limited to a 30-day supply when obtained at a retail or mail order pharmacy. You may access Our website at www.uhcsr.com or by calling 1-855-828-7716 for more information on supply limits for specialty Prescription Drugs.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our 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. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.uhcsr.com or by calling 1-855-828-7716. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Certificate.

10. Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment. If you have an Emergency Condition, You may immediately access without Preauthorization, a five (5) day emergency supply of a Covered Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. If You have a Copayment, it will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If you receive an additional supply of the Prescription Drug within the

30-day period in which You received the emergency supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

In this paragraph, “Emergency Condition” means a substance use disorder condition that manifests itself by Acute symptoms of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily function;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

11. Initial Supply of Prescription Opioid Drugs. If you received an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same 30-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

12. Cost-Sharing for Orally-Administered Anti-Cancer Drugs. Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Certificate.

D. Medical Management.

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

- 1. Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.

For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.uhcsr.com or call 1-855-828-7716. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available

Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Certificate. Your Provider may check with Us to find out which Prescription Drugs are Covered.

E. Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.
3. Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. Compounded Prescription Drugs are on tier 3.
4. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
5. Injectable drugs (other than self-administered injectable drugs) are not Covered under this section but are Covered under other sections of this Certificate. Your benefit for diabetic insulin, oral hypoglycemics, diabetic Prescription Drugs, and diabetic supplies, will be provided under this section of the Certificate if the Cost-Sharing is more favorable to You under this section of the Certificate than the Additional Benefits, Equipment and Devices section of this Certificate.
6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician’s office are Covered under the Outpatient and Professional Services section of this Certificate.
7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided

in accordance with the comprehensive guidelines supported by HRSA or with an “A” or “B” rating from USPSTF, or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.
11. A pharmacy need not dispense a Prescription Order that, in the pharmacist’s professional judgment, should not be filled.

F. General Conditions.

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.
2. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds (“rebates”) directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member’s utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may

be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Certificate).

- 1. Brand-Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as “brand name” by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.
- 2. Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.
- 3. Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six (6) times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at www.uhcsr.com or by calling 1-855-828-7716.
- 4. Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as “generic” by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.
- 5. Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.
- 6. Participating Pharmacy:** A pharmacy that has:
 - Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
 - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
 - Been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

- 7. Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.
- 8. Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, rate We have agreed to pay Our Participating Pharmacies, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.
- 9. Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.
- 10. Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the New York Education Law.

SECTION XIV

Wellness Benefits

A. Exercise Facility Reimbursement.

We will partially reimburse the Student for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility; and
- Complete 50 visits in a six (6)-month period.

In order to obtain reimbursement, at the end of the six-month period, You must submit:

- Documentation of the visits from the facility. Each time You visit the exercise facility, a facility representative must sign and date the documentation of the visits.
- A copy of Your current facility bill which shows the fee paid for Your membership.
- A copy of the brochure that outlines the services the exercise facility offers.

Once We receive documentation of the visits and the bill, You will be reimbursed the lesser of \$200 for the Student or the actual cost of the membership per six (6)-month period. Reimbursement must be requested within 120 days of the end of the six (6)-month period. Reimbursement will be issued only after You have completed each six (6)-month period even if 50 visits are completed sooner.

SECTION XV

Pediatric Vision Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits and any Preauthorization or Referral requirements that apply to these benefits.

A. Pediatric Vision Care.

We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns 19 years of age.

B. Vision Examinations.

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time per Plan Year, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Prescribed Lenses and Frames.

We Cover standard prescription lenses or contact lenses for Members through the end of the month in which the Member turns 19 years of age, one (1) time per Plan Year, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames for Members through the end of the month in which the Member turns 19 years of age, adequate to hold lenses one (1) time per Plan Year, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame. The difference in cost does not apply toward Your In-Network Out-of-Pocket Limit.

SECTION XVI

Pediatric Dental Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services for Members through the end of the month in which the Member turns 19 years of age:

- A. Emergency Dental Care.** We Cover emergency dental care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.
- B. Preventive Dental Care.** We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:
- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
 - Topical fluoride application two (2) times per Plan Year where the local water supply is not fluoridated;
 - Sealants on unrestored permanent molar teeth; and
 - Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
- C. Routine Dental Care.** We Cover routine dental care provided in the office of a dentist, including:
- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
 - X-rays, full mouth x-rays or panoramic x-rays at 36 month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
 - Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
 - In-office conscious sedation;
 - Amalgam, composite restorations and stainless steel crowns; and
 - Other restorative materials appropriate for children.
- D. Endodontics.** We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.
- E. Periodontics.** We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for the treatment related to hormonal disturbances, drug therapy or congenital defects. We

also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Certificate.

F. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures for Members 15 years of age and above, including six (6) months follow-up care;
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate; and
- Interim prosthesis for Members five (5) to 15 years of age.

We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of a device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of or leading to orthodontics that are otherwise Covered under this Certificate.

H. Orthodontics. We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION XVII

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

G. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

H. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

K. Medically Necessary.

In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the

service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

L. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

M. Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

N. No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

P. Services Provided by a Family Member.

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Q. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services With No Charge.

We do not Cover services for which no charge is normally made.

S. Vision Services.

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

T. War.

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

U. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION XVIII

Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 800-767-0700 or visiting Our website at www.uhcsr.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Certificate or visiting Our website at www.uhcsr.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Pre-Service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XIX

Grievance Procedures

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can contact Us by phone at 800-767-0700 or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:

By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances:

(A request for a service or a treatment that has not yet been provided.)

In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances:

(A claim for a service or a treatment that has already

In writing, within 30 calendar days of receipt of Your Grievance.

been provided.)

All Other Grievances:
(That are not in relation
to a claim or request for a service.)

In writing, within
45 calendar days of receipt
of all necessary information.

D. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XX

Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 800-767-0700. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed Physicians or licensed, certified, registered, or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call 800-767-0700 .

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.
3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You or Your designee certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You or Your designee and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period.
2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice

to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.
4. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a Participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within 48 hours of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

1. The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;

2. The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
3. We were not aware of the existence of such information at the time of the Preauthorization review; and
4. Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration.

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals.

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will, if necessary, inform You of any additional information needed before a decision can be made. The appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is: 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
 - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and

- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

- That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for

an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

- 4. Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file an expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

I. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017

Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org

Website: www.communityhealthadvocates.org

SECTION XXI

External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure Covered by Us; **or**

3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph “A” above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the

requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph “A” above.

In addition, Your attending Physician must: certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your Right to Appeal a Formulary Exception Denial.

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug section of this Certificate for more information on the formulary exception process.

G. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision. In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision.

The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional within 24 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of \$25 for each external appeal, not to exceed \$75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

H. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XXII

Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Student has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The date on which the Student ceases to meet the eligibility requirements as defined by the Policyholder. We will provide written notice to the Student at least 30 days prior to when the coverage will cease.
3. Upon the Student's death, coverage will terminate unless the Student has coverage for Dependents. If the Student has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. The end of the month during which the Student provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
5. If a Student has performed an act that constitutes fraud or the Student has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Student.
6. The date that the Policyholder's Policy is terminated. If We terminate and/or decide to stop offering a particular class of policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Policyholder and Students at least 90 days' prior written notice.
7. If We elect to terminate or cease offering student accident and health insurance coverage in this state, We will provide written notice to the Policyholder at least 180 days prior to when the coverage will cease.
8. The Policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
9. For such other reasons that are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the continuation of Coverage section of this Certificate for Your right to continuation of coverage.

SECTION XXIII

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability. If you are pregnant on the date Your coverage under this Certificate terminates, continued benefits may be available for Your maternity care.

For purposes of this section, “total disability” means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When You May Continue Benefit.

1. If You are totally disabled on the date Your coverage under this Certificate terminates, We will continue to pay for Your care under this Certificate during an uninterrupted period of total disability until the first of the following:
 - The date You are no longer totally disabled; or
 - 90 days from the date extended benefits began (if Your benefits are extended based on termination of Student status).
2. If You are pregnant on the date Your coverage under this Certificate terminates, We will continue to pay for Your maternity care under this Certificate through delivery and any post-partum services directly related to the delivery.

B. Limits on Extended Benefits.

We will not pay extended benefits:

- For any Member who is not totally disabled or pregnant on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

SECTION XXIV

Temporary Suspension Rights for Armed Forces' Members

If You, the Student, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. Your service ends during the Plan Year for which this Certificate is effective.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the premium within 60 days of the termination or active duty.

For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XXV

General Provisions

1. Agreements Between Us and Participating Providers.

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.

You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill. See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Choice of Law.

This Certificate shall be governed by the laws of the State of New York.

4. Clerical Error.

Clerical error, whether by the Policyholder or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

5. Conformity with Law.

Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

6. Continuation of Benefit Limitations.

Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Student, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Student.

7. Entire Agreement.

This Certificate including the Schedule of Benefits and any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

8. Furnishing Information and Audit.

All persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Policyholder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to enrollment at the Policyholder's New York office.

9. Identification Cards.

Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

10. Incontestability.

No statement made by the Student in an application for coverage under this Policy shall avoid the Policy or be used in any legal proceeding unless the application or an exact copy is attached to this Policy.

11. Material Accessibility.

We will give the Policyholder and the Policyholder will give You ID cards, Certificates, riders, and other necessary materials.

12. More Information about Your Health Plan.

You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g. Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.

- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

13. Notice.

Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to:

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

14. Premium Refund.

We will give any refund of Premiums which are paid by You, if due, to You.

15. Recovery of Overpayments.

On occasion, a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

16. Reinstatement after Default.

If the Student defaults in making any payment under this Certificate, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Certificate.

17. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of Health Care Professionals from various medical specialties. Conclusions of

the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a covered benefit.

18. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

19. Severability.

The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

20. Subrogation and Reimbursement.

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under Section 5-335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

21. Third Party Beneficiaries.

No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right,

benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

22. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within three (3) years from the date the claim was required to be filed.

23. Translation Services.

Translation services are available under this Certificate for non-English speaking Members. Please contact Us at 800-767-0700 to access these services.

24. Venue for Legal Action.

If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

25. Waiver.

The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

26. Who May Change this Certificate.

This Certificate may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

27. Who Receives Payment under this Certificate.

Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider. If You assign benefits for a surprise bill to Your Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Certificate for more information about surprise bills.

28. Workers' Compensation Not Affected.

The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

29. Your Medical Records and Reports.

In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

30. Your Rights.

You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

SECTION XXVI

Assistance and Evacuation Benefits

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

An international Student (whose Home Country is not the United States), is eligible to receive Assistance and Evacuation Benefits worldwide, except in their Home Country.

A domestic Student (whose Home Country is the United States), is eligible for Assistance and Evacuation Benefits when 100 miles or more away from their campus address or 100 miles or more away from their permanent home address or while participating in a study abroad program.

DEFINITIONS

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

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

“Home Country” means, with respect to a Member, the country or territory as shown on the Member’s passport or, if different, the country or territory of which the Member is a permanent resident.

“Host Country” means, with respect to a Member, the country or territory the Member is visiting or in which the Member is living, which is not the Member’s Home Country.

“Physician Advisors” mean physicians retained by the Company’s affiliate or authorized vendor for provision of consultative and advisory services to the Company’s affiliate or authorized vendor, including the review and analysis of the medical care received by Members.

MEDICAL EVACUATION AND REPATRIATION BENEFITS

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

Medical Evacuation and Repatriation benefits are covered if needed due to a Member's illness or injury. Coverage for such services does not extend to circumstances where the need for evacuation, repatriation or other related services is not triggered by accident or illness. For example, coverage for a Medical Evacuation under this Certificate does not extend to circumstances where an evacuation is needed due to a storm, security risk, epidemic, natural disaster or other similar circumstance.

Emergency Medical Evacuation: If a Member suffers a sickness or injury, experiences an Emergency Medical Event and adequate medical facilities are not available locally in the opinion of the *Medical Director* of the Company's affiliate or authorized vendor, the Company's affiliate or authorized vendor will provide an emergency medical evacuation (under medical supervision if necessary) from a land-based treatment location to the nearest facility capable of providing adequate care by whatever means is necessary. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the emergency medical evacuation.

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

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

Transportation after Stabilization: If medical repatriation is not required following stabilization of the Member's condition and discharge from the hospital, the Company's affiliate or authorized vendor will coordinate transportation from the Member's land-based location to the Member's point of origin, Home Country, or Host Country. The Company will pay costs for economy transportation (or upgraded transportation to match a Member's originally booked travel arrangements) to the Member's original point of origin, Home Country or Host Country.

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

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

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

CONDITIONS AND LIMITATIONS

Assistance and Evacuation Benefits shall only be provided to a Member after the Company's affiliate or authorized vendor receives the request (in writing or via phone) from the Member or an authorized representative of the Member of the need for the requested Assistance and Evacuation Benefits. Unless a Member is incapacitated and unable to contact the Company's affiliate or authorized vendor during an Emergency Medical Event for benefits to be available, the requested Assistance and Evacuation Benefits services and payments must be arranged,

authorized, verified and approved in advance by the Company's affiliate or authorized vendor to be covered. If a Member is incapacitated and unable to immediately contact the Company's affiliate or authorized vendor due to an Emergency Medical Event, the Member should notify the Company's affiliate or authorized vendor within 48 hours or as soon as reasonably possible.

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

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

In addition to the exclusions set forth in the Certificate, the following exclusions and limitations apply to the Assistance and Evacuation Benefits.

HOW TO ACCESS ASSISTANCE AND EVACUATION BENEFITS

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

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

When calling the emergency response center, the caller should be prepared to provide the following information:

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

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

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

SECTION XXVII

Rider for Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities

This rider amends Your Certificate with respect to Utilization Review for outpatient substance use disorder treatment at participating OASAS-certified facilities.

A. Outpatient Substance Use Disorder Treatment at Participating OASAS Certified Facilities.

Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first two (2) weeks of continuous treatment, not to exceed 14 visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within 48 hours. After the first two (2) weeks of continuous treatment, not to exceed 14 visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

B. Controlling Certificate

All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

**Section XXVII
SCHEDULE OF BENEFITS
METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 77.570%
Adelphi University - 2018-757-1**

COST-SHARING	Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing
Medical Deductible			
• Individual	None	\$150	\$300
• Family	None	None	None
Prescription Drug Deductible			
• Individual	None	\$50	\$50
Out-of-Pocket Limit			
• Individual	\$7,350	\$7,350	\$7,350
• Family	None	None	None
			<p>See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount.</p> <p>Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.</p>

OFFICE VISITS	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	See benefit for description
Specialist Office Visits (or Home Visits)	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	See benefit for description
PREVENTIVE CARE	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* • Adult Annual Physical Examinations* • Adult Immunizations* • Routine Gynecological Services/Well Woman Exams* • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer* • Sterilization Procedures for Women* 	<p>Covered in full</p> <p>Not Covered at SHC</p> <p>Covered in full</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	See benefit for description

<ul style="list-style-type: none"> Vasectomy 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Bone Density Testing* 	Not Covered at SHC	Covered in full	30% Coinsurance after Deductible	
<ul style="list-style-type: none"> Screening for Prostate Cancer <ul style="list-style-type: none"> Performed in a PCP Office 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Performed in a Specialist Office 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> All other preventive services required by USPSTF and HRSA. 	Not Covered at SHC	Covered in full	30% Coinsurance after Deductible	
<ul style="list-style-type: none"> *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. 	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	Not Covered at SHC	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

Non-Emergency Ambulance Services	Not Covered at SHC	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Emergency Department Copayment waived if Hospital admission	Not Covered at SHC	20% Coinsurance after Deductible \$250 Copayment	20% Coinsurance after Deductible \$250 Copayment	See benefit for description
Urgent Care Center	Not Covered at SHC	20% Coinsurance after Deductible \$75 Copayment	40% Coinsurance after Deductible \$75 Copayment	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Acupuncture	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
Advanced Imaging Services <ul style="list-style-type: none">Performed in a Specialist OfficePerformed in a Freestanding Radiology FacilityPerformed as Outpatient Hospital Services	Not Covered at SHC Not Covered at SHC Not Covered at SHC	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment <ul style="list-style-type: none">Performed in a PCP Office	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	See benefit for description

<ul style="list-style-type: none"> Performed in a Specialist Office 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
Ambulatory Surgical Center Facility Fee	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	See benefit for description
Anesthesia Services (all settings)	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Cardiac and Pulmonary Rehabilitation				See benefits for description
<ul style="list-style-type: none"> Performed in a Specialist Office 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Performed as Inpatient Hospital Services 	Not Covered at SHC	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	

<p>Chemotherapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	<p>See benefit for description</p>
<p>Chiropractic Services</p>	<p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p>	<p>See benefit for description</p>
<p>Clinical Trials</p>	<p>Not Covered at SHC</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>See benefit for description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	<p>See benefit for description</p>

<p>Dialysis</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed in a Freestanding Center Performed as Outpatient Hospital Services 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	<p>See benefit for description</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p>	
<p>Home Health Care</p>	<p>Not Covered at SHC</p>	<p>20% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	
<p>Infertility Services</p>	<p>Not Covered at SHC</p>	<p>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)</p>	<p>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)</p>	<p>See benefit for description</p>

<p>Infusion Therapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p> <p>20% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Inpatient Medical Visits</p>	<p>Not Covered at SHC</p>	<p>20% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Interruption of Pregnancy</p> <ul style="list-style-type: none"> Medically Necessary Abortions Elective Abortions 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>Covered in full after Deductible</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	<p>Unlimited</p> <p>One (1) procedure per Plan Year</p>
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>0% Coinsurance</p> <p>0% Coinsurance</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> Performed in a Freestanding Laboratory Facility Performed as Outpatient Hospital Services 	<p>0% Coinsurance</p> <p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> Prenatal Care <ul style="list-style-type: none"> Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA Inpatient Hospital Services and Birthing Center Physician and Nurse Midwife Services for Delivery Breastfeeding Support, Counseling and Supplies, including Breast Pumps Postnatal Care 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>Covered in full</p> <p>20% Coinsurance after Deductible</p>	<p>30% Coinsurance after Deductible</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p> <p>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

Outpatient Hospital Surgery Facility Charge	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	See benefit for description
Preadmission Testing	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities				See benefit for description
<ul style="list-style-type: none"> Performed in a PCP 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Performed in a Specialist Office 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Performed in Outpatient Facilities 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
Diagnostic Radiology Services				See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Performed in a Specialist Office 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	

<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	<p>See benefit for description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p>	
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p>	<p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.</p>	<p>See benefit for description</p>
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</p> <ul style="list-style-type: none"> Inpatient Hospital Surgery 	<p>Not Covered at SHC</p>	<p>20% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education				See benefit for description
<ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (Up to a 90-day supply) • Diabetic Education 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>0% Coinsurance not subject to Deductible \$20 Copayment</p> <p>0% Coinsurance after Deductible \$35 Copayment</p>	<p>0% Coinsurance not subject to Deductible \$20 Copayment</p> <p>40% Coinsurance after Deductible \$30 Copayment</p>	
Durable Medical Equipment and Braces	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

External Hearing Aids	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) per ear per time Covered
Hospice Care				210 days per Plan Year
<ul style="list-style-type: none"> • Inpatient 	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Five (5) visits for family bereavement counseling
<ul style="list-style-type: none"> • Outpatient 	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Medical Supplies	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices				One (1) prosthetic device, per limb, per Plan Year with coverage for repairs and replacements
<ul style="list-style-type: none"> • External 	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> • Internal 	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
INPATIENT SERVICES and FACILITIES	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits

Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	200 days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital)	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	See benefit for description
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital)	Not Covered at SHC	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	Not Covered at SHC	0% Coinsurance after Deductible \$35 Copayment	40% Coinsurance after Deductible \$30 Copayment	Up to 20 visits per Plan Year may be used for family counseling
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy				
30-day supply If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage	Not Covered at SHC	Tier 1 \$20 Copayment 20% Coinsurance after Deductible Tier 2 \$40 Copayment 40% Coinsurance after Deductible	Generic \$20 Copayment 20% Coinsurance after Deductible Brand-Name \$40 Copayment 40% Coinsurance after Deductible	See benefit for description

opioid withdrawal and/or stabilization and for opioid overdose reversal.		Tier 3 \$60 Copayment 40% Coinsurance after Deductible		
Mail Order Pharmacy				
Up to a 90-day supply	Not Covered at SHC	2.5 times the retail Copayment	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Enteral Formulas	Not Covered at SHC	No Benefit	No Benefit	See benefit for description
WELLNESS BENEFITS	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost- Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Exercise Facility Reimbursement	Not Covered at SHC	Up to \$200 per six (6) month period		Up to \$200 per six (6) month period
PEDIATRIC DENTAL and VISION CARE	Preferred Provider and Student Health Center (SHC) Member Responsibility for Cost- Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits

<p>Pediatric Dental Care</p> <ul style="list-style-type: none"> Preventive Dental Care Routine Dental Care Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) Orthodontics <p>Orthodontics and Major Dental Require Preauthorization</p>	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Orthodontics and Major Dental Require Preauthorization</p>	<p>\$35 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$100 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$350 Copayment 0% Coinsurance not subject to Deductible</p> <p>50% Coinsurance not subject to Deductible</p> <p>Orthodontics and Major Dental Require Preauthorization</p>	<p>\$35 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$100 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$350 Copayment 0% Coinsurance not subject to Deductible</p> <p>50% Coinsurance not subject to Deductible</p> <p>Orthodontics and Major Dental Require Preauthorization</p>	<p>One (1) dental exam and cleaning per six (6)-month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) to 12-month intervals</p>
<p>Pediatric Vision Care</p> <ul style="list-style-type: none"> Exams Lenses and Frames Contact Lenses 	<p>Not Covered at SHC</p> <p>Not Covered at SHC</p> <p>Not Covered at SHC</p>	<p>\$20 Copayment not subject to Deductible</p> <p>\$40 Copayment not subject to Deductible</p> <p>\$40 Copayment not subject to Deductible</p>	<p>50% Coinsurance not subject to Deductible</p> <p>50% Coinsurance not subject to Deductible</p> <p>50% Coinsurance not subject to Deductible</p>	<p>One (1) exam per Plan Year</p> <p>One (1) prescribed lenses and frames per Plan Year</p>

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Certificate, You will be responsible for the full cost of the services.

POLICY NUMBER: 2018-757-1

NOTICE:

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

NOC4 - 09/26/2018

CERTIFICATE:

Diabetic Equipment, Supplies and Insulin

FROM

Participating Provider Member Responsibility for Cost-Sharing 0% Coinsurance after Deductible \$35 Copayment

Non-Participating Provider Member Responsibility for Cost-Sharing 40% Coinsurance after Deductible \$35 Copayment

TO

Participating Provider Member Responsibility for Cost-Sharing 0% Coinsurance not subject to Deductible \$20 Copayment

Non-Participating Provider Member Responsibility for Cost-Sharing 0% Coinsurance not subject to Deductible \$20 Copayment

Diabetic Education

FROM

Participating Provider Member Responsibility for Cost-Sharing 20% Coinsurance after Deductible

Non-Participating Provider Member Responsibility for Cost-Sharing 40% Coinsurance after Deductible

TO

Participating Provider Member Responsibility for Cost-Sharing 0% Coinsurance after Deductible \$35 Copayment

Non-Participating Provider Member Responsibility for Cost-Sharing 40% Coinsurance after Deductible \$30 Copayment

Home Infusion Therapy

FROM

Participating Provider Member Responsibility for Cost-Sharing 0% Coinsurance after Deductible \$35 Copayment

Non-Participating Provider Member Responsibility for Cost-Sharing 40% Coinsurance after Deductible \$30 Copayment

TO

Participating Provider Member Responsibility for Cost-Sharing 20% Coinsurance after Deductible

Non-Participating Provider Member Responsibility for Cost-Sharing 40% Coinsurance after Deductible

NOC3 - 09/11/2018

CERTIFICATE:

ADDITIONAL SERVICES, EQUIPMENT and DEVICES

ABA Treatment for Autism Spectrum Disorder and Diabetic Equipment, Supplies and Insulin (Up to a 90-day supply)

FROM

Participating Provider Member Responsibility for Cost-Sharing 20% Coinsurance after Deductible

Non-Participating Provider Member Responsibility for Cost-Sharing 40% Coinsurance after Deductible

TO

Participating Provider Member Responsibility for Cost-Sharing 0% Coinsurance after Deductible \$35 Copayment

Non-Participating Provider Member Responsibility for Cost-Sharing 40% Coinsurance after Deductible \$30

Copayment

Added Section XXVII Rider for Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities

NOC2 - 09/10/2018

Certificate:

Non-Participating Provider Member Responsibility for Cost-Sharing

Specialist Office Visits

(or Home Visits)

FROM \$35 Copayment

TO \$30 Copayment

NOC1 - 09/07/2018

Certificate:

All applicable Participating Office Visit copays were changed FROM 20% coins. after Deductible \$15 copayment' TO '0% coinsurance after Deductible \$35 copayment'.

Summary Brochure:

Removed section UnitedHealthcare Global: Global Emergency Services and added new section Highlights of Medical Evacuation and Repatriation Benefits

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**ភាសាខ្មែរ(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 yáníti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjí' 1-866-260-2723 hodílnih.

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