UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT INJURY AND SICKNESS INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of

California Institute of the Arts

2020-2021

This Certificate of Coverage is Part of Policy # 2020-756-1

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

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

NOTICE: THE INSURED SHOULD REVIEW THE DEFINITIONS IN THIS CERTIFICATE OF COVERAGE TO UNDERSTAND HOW BENEFITS ARE PAID.

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

Table of Contents

Introduction

Welcome to the UnitedHealthcare **Student**Resources Student Injury and Sickness Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance Company ("the Company").

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

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

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

The Insured may also call the Customer Service Department at 1-800-767-0700, toll free, for assistance in finding a Preferred Provider.

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-800-767-0700. The Insured can also write to the Company at:

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

Section 1: Who Is Covered

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

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

All registered domestic and international students taking one (1) or more credit hours are required to register in this insurance plan, unless proof of comparable coverage is furnished. All international students are required to have a J-1, F-1 or M-1 Visa to be eligible for this insurance plan. Dependents are eligible to enroll in this insurance plan on a voluntary basis.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children under 26 years of age. See the Definitions section of this Certificate for the specific requirements needed to meet Domestic Partner eligibility.

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

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

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:

a. On the date the Named Insured acquires a legal spouse or enters into a Domestic Partnership with a Domestic Partner who meets the specific requirements set forth in the Definitions section of this Certificate.
b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., September 1, 2020. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 31, 2021. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

Section 3: Extension of Benefits after Termination

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

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

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

Section 4: Pre-Admission Notification

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

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

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

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

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

Section 5: Preferred Provider Information

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

United Healthcare Choice Plus

The availability of specific providers is subject to change without notice. A list of Preferred Providers is located on the plan's web site at www.uhcsr.com. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

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

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

Inpatient Expenses

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

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

Medical Emergency

For the purposes of PPO coverage, Medical Emergency includes Active Labor. Active Labor means a labor at a time at which either of the following would occur:

1. There is inadequate time to make a safe transfer to another hospital prior to delivery.
2. A transfer may pose a threat to the health and safety of the Insured or the unborn child.

Surprise Bills

A surprise bill is a bill for Covered Medical Expenses, other than Emergency Services, received by an Insured Person which is:

1. For services rendered by an Out-of-Network Physician at a Preferred Provider facility.
2. Not agreed to in advance in a written agreement between the Out-of-Network Physician and the Insured Person.

When an Insured Person receives a surprise bill for Covered Medical Expenses at a Preferred Provider facility from an Out-of-Network Physician, benefits shall be paid the same as if the Physician were a Preferred Provider.

An Insured Person shall not owe the Out-of-Network Physician more than the Preferred Provider Cost-Sharing Amount. At the time of payment for such Covered Medical Expenses, the Company shall inform the Insured and the Out-of-Network Physician of the Preferred Provider Cost-Sharing Amount owed by the Insured.

An Out-of-Network Physician shall not bill or collect any amount from the Insured Person for Covered Medical Expenses in excess of the Preferred Provider Cost-Sharing Amount. If the Out-of-Network Physician receives payment in excess of the Preferred Provider Cost-Sharing Amount, the Out-of-Network Physician must refund the overpayment to the Insured within 30 calendar days after receiving the payment. If the Out-of-Network Physician does not refund the overpayment within 30 calendar days after being informed of the Preferred Provider Cost-Sharing Amount, interest shall accrue at the rate of 15 percent per annum beginning on the date the payment was received from the Insured.

Preferred Provider Cost-Sharing Amount includes any Copayment, Coinsurance, or Deductible paid by the Insured for service performed by a Preferred Provider. This does not include any premium payments made by the Insured.

If the Policy includes Out-of-Network benefits, the Insured shall be responsible for the Out-of-Network cost-sharing amount only when the Insured consents in writing, and that consent meets all the following criteria:

1. The services to be performed are Covered Medical Expenses under the Policy.
2. The written consent is signed at least 24-hours in advance of the care.
3. The consent shall be obtained by the Out-of-Network Physician in a document that is separate from any other document used to obtain the Insured's consent for care.
4. At the time of consent, the Out-of-Network Physician shall provide the Insured with a written estimate of the Insured's total expected Out-of-Pocket cost.
5. The consent shall advise the Insured that care may be obtained from a Preferred Provider at a lower cost.

If an Out-of-Network Physician does not obtain prior consent, then the Out-of-Network Physician must accept the Preferred Provider Cost-Sharing Amount as explained above.

Continuity of Care

If an Insured is undergoing a course of treatment with a Preferred Provider for one of the medical conditions listed below, and the Preferred Provider's contract is terminated by the Company, then the Company will arrange for continuation of Covered Medical Expenses at the Insured's request and subject to the provider's agreement. The continued Covered Medical Expenses are limited to the time periods shown below and while the Insured is Covered by this Policy for each type of condition.

Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Policy will be the same as an Insured would have paid for a current Preferred Provider.

Medical conditions and time periods for which continued benefits could be provided are:

1. **Acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to a Sickness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Medical Expenses will be provided for the duration of the acute condition.

2. **Serious chronic condition.** A serious chronic condition is a medical condition caused by a Sickness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or require ongoing treatment to maintain remission or prevent deterioration. Benefits shall be provided for a period of time necessary to complete a course of treatment or to arrange for a safe transfer to another provider, as determined by the Company in consultation with the Insured and the terminated provider and consistent with good professional practice. Completion of Covered Medical Expenses shall not exceed 12 months from the provider's contract termination date.

3. **Terminal Illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completions of Covered Medical Expenses shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date.

4. **Pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Medical Expenses shall be provided for the duration of the pregnancy.

   For an Insured who presents written documentation of being diagnosed with a maternal mental health condition, completion of Covered Medical Expenses provided for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later.

5. **Care of a newborn child between birth and age 36 months.** Completion of Covered Medical Expenses shall not exceed 12 months from the provider's contract termination date.

6. **Performance of surgery or other procedure.** Completion of Covered Medical Expenses shall be provided for a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days from the provider's contract termination date.

Coverage will not be continued for treatment by a provider or provider group whose contract has been terminated or not renewed for reasons related to medical disciplinary cause or reason, fraud, or other criminal activity.

Section 6: Medical Expense Benefits – Injury and Sickness

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

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

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

Inpatient

1. **Room and Board Expense.**
   Daily semi-private room rate when confined as an Inpatient and general nursing care, including Medically Necessary special duty nursing, provided and charged by the Hospital.

   Benefits also include daily private room rate, when Medically Necessary.

2. **Intensive Care.**
   Intensive Care services as provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia.
   - Drugs (excluding take home drugs) or medicines.
   - Therapeutic services.
   - Supplies.

4. **Routine Newborn Care.**
   While Hospital Confined and routine nursery care provided immediately after birth.

   Benefits will be paid for an inpatient stay of at least:
   - 48 hours following a vaginal delivery.
   - 96 hours following a cesarean section delivery.

   If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames. If released early, benefits will be provided for a post-discharge follow-up visit within 48 hours of discharge, when prescribed by the attending Physician.

   Benefits include Newborn Infant care provided up to 31 days after birth as specified in the Newborn Infant definition.

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

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

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

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

   General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is covered under the Room and Board Expense benefit.

9. **Physician's Visits.**
   Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**
    Benefits are limited to routine tests such as:
    - Complete blood count.
    - Urinalysis.
    - Chest X-rays.

    If otherwise payable under the Policy, major diagnostic procedures such as those listed below will be paid under the Hospital Miscellaneous benefit:
    - CT scans.
    - NMR's.
    - Blood chemistries.

Outpatient

11. **Surgery.**
    Physician's fees for outpatient surgery.

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

13. **Assistant Surgeon Fees.**
    Assistant Surgeon Fees in connection with outpatient surgery.

14. **Anesthetist Services.**
    Professional services administered in connection with outpatient surgery.

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

    Physician's Visits for preventive care are provided as specified under Preventive Care Services.

16. **Physiotherapy.**
    Includes but is not limited to the following rehabilitative services (including Habilitative Services):
    - Physical therapy.
    - Occupational therapy.
    - Cardiac rehabilitation therapy.

- Manipulative treatment, unless excluded in the Policy.
- Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.

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

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

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

19. **Radiation Therapy.**
    See Schedule of Benefits.

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

21. **Tests and Procedures.**
    Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
    - Physician's Visits.
    - Physiotherapy.
    - X-rays.
    - Laboratory Procedures.

    The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
    - Inhalation therapy.
    - Infusion therapy.
    - Pulmonary therapy.
    - Respiratory therapy.
    - Dialysis and hemodialysis.

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

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

23. **Chemotherapy.**
    See Schedule of Benefits.

24. **Prescription Drugs.**
    See Schedule of Benefits.

    If an Insured Person receives a partial fill of a prescription for an oral, solid-dosage Schedule II Controlled Substance, the cost-sharing shall be pro-rated for each partial fill until the prescription has been fully dispensed.

    If an Insured Person receives preexposure prophylaxis furnished by a pharmacist, benefits are limited to a 60-day supply issued to a single Insured Person once every two years, unless the pharmacist has been otherwise directed by a written prescription from a Physician.

Other

25. **Ambulance Services.**
    See Schedule of Benefits.

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

    For the purposes of this benefit, the following are considered durable medical equipment.
    - Braces that stabilize an injured body part and braces to treat curvature of the spine.
    - External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
    - Post-Mastectomy bras limited to 3 bras per Policy Year.

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

    See also Benefits for Prosthetic Devices for Speaking Post Laryngectomy.

27. **Consultant Physician Fees.**
    Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**
    Dental treatment when services are performed by a Physician and limited to the following:
    - Injury to Natural Teeth.

    Benefits will also be paid the same as any other Sickness for:
    - Dental services to prepare the Insured's jaw for radiation therapy of cancer in the head or neck. Benefits include dental evaluations, x-rays, fluoride treatment, and extractions when services are provided by a Physician or by a Dentist, when referred by a Physician.
    - Facility and general anesthesia charges associated with a dental procedure which would not ordinarily require general anesthesia when the Insured:
        1) Is under age 7.
        2) Is developmentally disabled or whose health is compromised.
        3) Has an underlying medical condition which requires that the dental procedure be provided in a Hospital or outpatient surgery center.
    - Dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services which are an integral part of a covered reconstructive surgery for cleft palate.

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

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

29. **Mental Illness Treatment.**
    Benefits will be paid for the following:
    - Services received on an Inpatient basis while confined to a Hospital or residential treatment facility.
    - Outpatient office visits including, but not limited to, Physician office visits and treatment and counseling, including individual and group therapy visits.
    - Other services received on an outpatient basis, including but not limited to:
        - Outpatient facility charges.
        - Partial hospitalization/day treatment services received on an outpatient basis at a Hospital or other licensed facility.
        - Medically Necessary hormone and surgical treatment for gender dysphoria.

- Intensive outpatient treatment.
- Diagnostic tests and procedures.
- Electroconvulsive and repetitive transcranial magnetic stimulation therapy.

- Prescription Drugs.

See also Benefits for Severe Mental Illnesses and Serious Emotional Disturbances.

30. **Substance Use Disorder Treatment.**
Benefits will be paid for the following:
- Services received on an Inpatient basis while confined to a Hospital or residential treatment facility.
- Outpatient office visits including, but not limited to, Physician office visits and treatment and counseling, including individual and group therapy visits.
- Other services received on an outpatient basis, including but not limited to:
  - Outpatient facility charges.
  - Partial hospitalization/day treatment services received on an outpatient basis at a Hospital or other licensed facility.
  - Intensive outpatient treatment.
  - Diagnostic tests and procedures.
  - Electroconvulsive and repetitive transcranial magnetic stimulation therapy.
- Prescription Drugs.

31. **Maternity.**
Same as any other Sickness.

Benefits will be paid for an inpatient stay of at least:
- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. If released early, benefits will be provided for a post-discharge follow-up visit within 48 hour of discharge, when prescribed by the attending Physician.

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

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

Examples of Preventive Care Services include, but are not limited to, the following:
- Reasonable health appraisal examinations on a periodic basis (routine physicals, well-child visits).
- Preventive vision screening and hearing exams.
- Health education counseling and programs for tobacco cessation, stress management, and chronic conditions, such as diabetes and asthma.
- A 90-day treatment regimen for FDA approved prescription and over-the-counter tobacco cessation medications when prescribed by a Physician.
- Well-woman examinations, including routine prenatal care visits.
- All FDA approved contraceptive drugs or devices for women.
- Testing for sexually transmitted diseases.
- Cytology examinations on a reasonable periodic basis.
- Female sterilization.

Required preventive care services are updated on an ongoing basis as guidelines and recommendations change. The complete and current list of preventive care services covered under the health reform law can be found at: https://www.healthcare.gov/preventive-care-benefits/.

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

Benefits include:
- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of mastectomy, including lymphedemas.

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

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

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

37. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of twelve months or less. All hospice care must be received from a licensed hospice agency for the palliation and management of an Insured's terminal illness and related conditions.

Hospice care includes:
- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Palliative care, including pharmaceuticals, medical equipment and supplies.
- Physician services.
- Physical, occupational or speech therapy for the purpose of symptom control or to maintain activities of daily living.
- Respiratory therapy.
- Home health aide services for the personal care of the terminally ill Insured.
- Homemaker services to assist in the maintenance of a safe and healthy environment and services to enable the Insured to carry out the treatment plan.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care and for one year after the Insured's death.
- Skilled nursing services, including assessment, evaluation and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to the Insured and the Insured's family, and instructions to caregivers.
- Physical therapy, occupational therapy and speech-language pathology services for the purpose of symptom control or to enable the Insured to maintain activities of daily living and basic functional skills.
- Respite care, limited to five consecutive days at a time, when necessary to relieve the Insured's caregiver.
- Nursing care services on a continuous basis for as much as 24-hours a day during periods of crisis as necessary to maintain an Insured at home.

38. **Inpatient Rehabilitation Facility.**
Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility.

39. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility.

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

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

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

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

42. **Approved Clinical Trials.**
Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the Policy. Routine patient care costs do not include:
- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the Policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.

No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined).

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

44. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits sections of this Certificate of Coverage.

45. **Acupuncture Services.**
Benefits are payable for Medically Necessary acupuncture services.

46. **Medical Foods.**
Benefits are payable for elemental dietary enteral formulas for the primary therapy for regional enteritis (Crohn's Disease). Medical foods must be prescribed by a Physician. The written prescription must accompany the claim when submitted.
See also Benefits for Phenylketonuria.

47. **Ostomy and Urological Supplies.**
Benefits are limited to the following supplies:

- Ostomy supplies, including: adhesives and adhesive remover, ostomy belt, hernia belt, catheter, skin wash/cleaner, bedside drainage bag and bottle, urinary leg bags, gauze pads, irrigation faceplate, irrigation sleeve, irrigation bag, irrigation cone/catheter, lubricant, urinary connectors, gas filters, ostomy deodorants, drain tube attachment devices, gloves, stoma caps, colostomy plug, ostomy inserts, urinary and ostomy pouches, barriers, pouch closures, ostomy rings, ostomy face plates, skin barrier, skin sealant and tape (waterproof and non-waterproof).
- Urological supplies, including: adhesive catheter skin attachment, catheter insertion trays with and without catheter and bag, male and female external collecting devices, male external catheter with integral collection chamber, irrigation tubing sets, indwelling catheters, foley catheters, intermittent catheters, cleaners, skin sealants, bedside and leg drainage bags, bedside drainage bottle, catheter leg straps, irrigation tray, irrigation syringe, lubricating gel, sterile individual packets, tubing and connectors, catheter clamp or plug, penile clamp, urethral clamp or compression device, tape (waterproof and non-waterproof), and catheter anchoring device.

Benefits are not available for ostomy and urological supplies that are comfort, convenience, or luxury equipment or features for other items that are not listed above.

48. **Vision Correction.**
Benefits are payable only for the following:
- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) per Policy Year to treat aniridia.
- Up to six Medically Necessary contact lenses per eye (including fitting and dispensing) per Policy Year to treat aphakia for Insureds through age 9.

Section 7: Mandated Benefits

BENEFITS FOR TELEHEALTH SERVICES

Benefits for appropriately provided Telehealth services will be paid on the same basis as services provided through a face-to-face contact between a Physician and Insured.

“Asynchronous store and forward” means the transmission of a patient’s medical information from an originating site to the health care Provider at a distant site without the presence of the patient.

“Synchronous interaction” means a real-time interaction between a patient and a health care provider located at a distant site.

“Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-managements of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

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

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid for screening by low-dose mammography for the presence of occult breast cancer, upon the referral of a nurse practitioner, certified nurse midwife, or Physician, subject to the following guidelines:

1. A baseline mammogram for women thirty-five to thirty-nine years of age, inclusive.
2. A mammogram every two years for women forty to forty-nine years of age or more frequently based on the woman’s Physician’s recommendation.
3. An annual mammogram for women fifty years of age or older.

Mammograms covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Mammograms not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Mammograms not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR UPPER OR LOWER JAWBONE SURGERY

Benefits will be paid the same as any other Injury or Sickness for surgical procedures for those covered conditions directly affecting the upper or lower jawbone, or associated bone joints provided the service is considered a Medical Necessity and does not include dental procedures other than those identified in the Schedule of Benefits.

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

BENEFITS FOR RECONSTRUCTIVE SURGERY

Benefits will be paid the same as any other Injury or Sickness for reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function; or (2) to create a normal appearance, to the extent possible.

This benefit does not include cosmetic surgery or surgery performed to alter or reshape normal structures of the body in order to improve the Insured's appearance, except for Reconstructive Breast Surgery following Mastectomy.

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

BENEFITS FOR PROSTHETIC DEVICES FOR SPEAKING POST LARYNGECTOMY

Benefits will be paid the same as any other prosthetic device for Prosthetic Devices to restore a method of speaking incident to a laryngectomy.

For the purposes of this section "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices, including installation accessories, pursuant to an order of the Insured's Physician and surgeon. "Prosthetic devices" does not include electronic voice producing machines.

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

BENEFITS FOR SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES

Benefits will be paid the same as any other Mental Illness for the diagnosis and Medically Necessary treatment of Severe Mental Illnesses of an Insured of any age and of Serious Emotional Disturbances of an Insured child as specified below:

1. Outpatient services.
2. Inpatient hospitalization services.
3. Partial hospitalization services.
4. Prescription Drugs.

"Severe Mental Illness" includes:

1. Schizophrenia.
2. Schizoaffective disorder.
3. Bipolar disorder (manic-depressive disorder).
4. Major depressive disorders.
5. Panic disorder.
6. Obsessive-Compulsive disorder.
7. Pervasive developmental disorder or Autism.
8. Anorexia nervosa.
9. Bulimia nervosa.

"Serious emotional disturbance of a child" means a child under the age of 18 years who has one or more mental disorders as identified in the most recent edition of the ***Diagnostic and Statistical Manual of Mental Disorders***, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population must meet one or more of the following criteria:

1. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following

occur: (i) the child is at risk of removal from home or has already been removed from the home. (ii) The mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment.
2. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
3. The child meets special education eligibility requirements under Chapter 26.5 of division 7 of Title 1 of the Government Code.

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

BENEFITS FOR BEHAVIORAL HEALTH TREATMENT FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

Benefits will be paid the same as any other Mental Illness for the diagnosis and Medically Necessary Behavioral Health Treatment for Pervasive Developmental Disorder or Autism.

"Behavioral Health Treatment" means professional services and treatment programs, including applied behavioral analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism, and that meet all the following:

1. The treatment is prescribed by a licensed Physician or Psychologist.
2. The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider that is administered by:
   a. A Qualified Autism Service Provider.
   b. A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
   c. A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or by a Qualified Autism Service Professional.
3. The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific Insured Person being treated. The treatment plan shall be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate. In the plan, the Qualified Autism Service Provider shall:
   a. Describe the Insured Person's behavioral health impairments to be treated.
   b. Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goals and objectives, and the frequency at which the Insured Person's progress is evaluated and reported.
   c. Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism.
   d. Discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
4. The treatment plan is not used for the purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the Company upon request.

For Medically Necessary Behavioral Health Treatment, benefits shall not be denied or unreasonably delayed based on:

1. An asserted need for cognitive, developmental, or intelligence quotient (IQ) testing.
2. The grounds that Behavioral Health Treatment is experimental, investigational, or educational.
3. The grounds that Behavioral Health Treatment is not being, will not be, or was not provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies.
4. The grounds that Behavioral Health Treatment has been, is being, should be, or will be provided by a Regional Center contracting with the Department of Developmental Services.
5. The grounds that an annual visit limit has been reached or exceeded.
6. Any other reason.

"Qualified autism service provider" means either of the following:

1. A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
2. A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-

language pathologist, or audiologist pursuant to Division 2 of the Business and Professions Code, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the licensee.

"Qualified autism service professional" means an individual who meets all of the following criteria:

1. Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider.
2. Is supervised by a Qualified Autism Service Provider.
3. Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
4. Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
5. Has training and experience in providing services for Pervasive Developmental Disorder or Autism pursuant to Division 4.5 of the Welfare and Institutions Code or Title 14 of the Government Code.
6. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Services Providers responsible for the Autism treatment plan.

"Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

1. Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
2. Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
3. Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
4. Has adequate education, training, and experience, as certified by a Qualified Autism Services Provider or an entity or group that employs Qualified Autism Service Providers.
5. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the Autism treatment plan.

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

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the management and treatment of insulin using diabetes, non-insulin using diabetes, and gestational diabetes as Medically Necessary even if the items are available without a prescription:

1. Blood glucose monitors and blood glucose testing strips.
2. Blood glucose monitors designed to assist the visually impaired.
3. Insulin pumps and all related necessary supplies.
4. Ketone urine testing strips.
5. Lancets and lancet puncture devices.
6. Pen delivery systems for the administration of insulin.
7. Podiatric devices to prevent or treat diabetes-related complications.
8. Insulin syringes.
9. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Benefits will also be provided for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable the Insured to properly use the equipment, supplies and medications noted above. The same policy limits will apply as apply to any other Physician's Visits.

Benefits will be paid the same as any other Prescription Drug for the following Medically Necessary prescriptions:

1. Insulin.
2. Prescriptive medications for the treatment of diabetes.
3. Glucagon.

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

BENEFITS FOR PHENYLKETONURIA

Benefits will be paid for the Usual and Customary Charges for the testing and treatment of Phenylketonuria (PKU).

Benefits include those Formulas and Special Food Products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Benefits are not required except to the extent that the cost of necessary Formulas and Special Food Products exceeds the cost of a normal diet.

"Formula" means an enteral product for use at home prescribed by a Physician or nurse practitioner or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments as Medically Necessary for the treatment of PKU.

"Special food product" means a food product that is both:

1. Prescribed by a Physician or nurse practitioner for the treatment of PKU and is consistent with the recommendations and best practices of qualified health professional with expertise germane to, and experienced in the treatment and care of, PKU. It does not include a food that is naturally low in protein, but may include a food product that is specifically formulated to have less than one gram of protein per serving.
2. Used in place of normal food products, such as grocery store foods, used by the general population.

The Deductible, Copayment and Coinsurance provisions of the Policy shall not apply; however, all other Policy limitations and provisions will apply.

BENEFITS FOR OSTEOPOROSIS

Benefits will be paid for the Usual and Customary Charges for the diagnosis, treatment and appropriate management of Osteoporosis. Benefits include all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

The Deductible, Copayment and Coinsurance provisions of the Policy shall not apply; however, all other Policy limitations and provisions will apply.

BENEFITS FOR BREAST CANCER SCREENING AND TREATMENT

Benefits will be paid the same as any other Sickness for the screening for, diagnosis of, and treatment for breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's participating Physician. The length of hospital stay shall be determined by the Insured's Physician and surgeon in consultation with the Insured.

Treatment for breast cancer shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy.

"Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons, as determined by a licensed Physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of a tumor with clear margins.

"Prosthetic device" means the provision of initial and subsequent devices as ordered by an Insured Person's Physician and surgeon.

Breast cancer screenings covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Breast cancer screenings not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Breast cancer screenings not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Benefits for prosthetic devices and reconstructive surgery shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR AIDS VACCINE

Benefits will be paid for the Usual and Customary Charges for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration (excluding an investigational new drug application) and that is recommended by the United States Public Health Service.

The Deductible, Copayment and Coinsurance provisions of the Policy shall not apply; however, all other Policy limitations and provisions will apply.

BENEFITS FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTS

Benefits will be paid for Human Immunodeficiency Virus (HIV) testing, regardless of whether the test is related to a primary HIV diagnosis. The testing method shall be that which is approved by the federal Food and Drug Administration and is recommended by the United States Public Health Service.

HIV testing covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

HIV testing not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

HIV testing not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid for screening and diagnosis of prostate cancer, including, but not limited to prostate-specific antigen testing (PSA) and digital rectal examinations when medically necessary and consistent with good professional practice.

Prostate cancer screenings covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Prostate cancer screenings not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Prostate cancer screenings not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CANCER SCREENING TESTS

Benefits will be paid for all generally medically accepted cancer screening tests.

Cancer screenings covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Cancer screenings not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Cancer screenings not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network +Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CERVICAL CANCER SCREENING

Benefits will be paid for an annual cervical cancer screening test, upon the referral of a nurse practitioner, certified nurse midwife, or Physician.

An annual screening test will include:

1. The conventional Pap test.
2. A human papilloma virus screening test that is approved by the federal Food and Drug Administration.
3. The option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon referral by the Insured's health care provider.

Cervical cancer screenings covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Cervical cancer screenings not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Cervical cancer screenings not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR OUTPATIENT CONTRACEPTIVE DRUGS AND METHODS

Benefits will be provided for prescribed contraceptive drugs and methods which are:

1. Approved by the Federal Food and Drug Administration.
2. Prescribed by the Insured's Physician.
3. Medically appropriate for the Insured.

Benefits will also be provided for up to a 12-month supply of contraceptive drugs when prescribed to be dispensed at one time.

Outpatient contraceptive drugs and methods covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Outpatient contraceptive drugs and methods not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Outpatient contraceptive drugs and methods not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

Benefits will be paid for prescribed, orally administered anticancer medications prescribed for cancer treatment used to kill or slow the growth of cancerous cells.

The total Copayment and Coinsurance an Insured Person is required to pay shall not exceed $250 for an individual prescription of up to a 31-day supply per prescription.

Benefits shall be subject to all Deductible, limitations, and any other provision of the Policy.

Section 8: Coordination of Benefits Provision

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

Definitions

1. **Allowable Expenses:** Any health care expense, including Coinsurance, or Copays and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health Plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health Plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.
   - The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms, except when the private room is Medically Necessary.
   - For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
   - For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
   - If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

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

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

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

   Plan does not include any of the following:

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

- State Plans under Medicaid.
- A governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other nongovernmental Plan.
- An Individual Health Insurance Contract.

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

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

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

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

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

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

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

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

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

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

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

2. **Dependent Child/Parents Married or Living Together.** When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:
   - the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
   - However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

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

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

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

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

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

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

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

6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   - First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
   - Second, the benefits under the COBRA or continuation coverage.
   - If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

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

Facility of Payment and Recovery - Whenever payments which should have been made under our coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any

amounts that are needed in order to satisfy the intent of this provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

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

Section 9: Definitions

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

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

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

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

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

DEPENDENT means the legal spouse or Domestic Partner of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

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

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

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

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

DOMESTIC PARTNER means a person who has filed a Declaration of Domestic Partnership with the California Secretary of State and who meets all of the following:

1. Is unmarried or is not a member of another domestic partnership.
2. Is not related by blood to the Insured Person in a way that would prevent marriage in this state.
3. Is at least 18 years of age; or, if under age 18, has, in accordance with California Law, obtained:
   a. Written consent from the underage person's parents and a court order granting permission to establish a domestic partnership; or
   b. A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent of legal guardian capable of consenting to the domestic partnership.
4. Is mentally capable of consenting to the domestic partnership.

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

EMERGENCY SERVICES means with respect to a Medical Emergency:

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

HABILITATIVE SERVICES means health care services and devices that help a person keep, learn, or improve skills and functions for daily living. Examples are therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings or both. Habilitative services must be covered under the same terms and conditions as rehabilitative services.

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

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

INJURY means bodily injury which is all of the following:

1. Caused by accidental contact with another body or object.
2. Unrelated to any pathological, functional, or structural disorder.
3. A source of loss.
4. Treated by a Physician.
5. Sustained while the Insured Person is covered under the Policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental illness does not include those conditions defined in Benefits for Severe Mental Illness and Serious Emotional Disturbances. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all mental health or psychiatric diagnoses are considered one Sickness.

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

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

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

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

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

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

POLICY OR MASTER POLICY means the entire agreement issued to the Policyholder that includes all of the following:

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

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

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

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

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

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

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

NATURAL TEETH means natural teeth, where the major portion of the individual tooth is present, regardless of fillings or caps.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic*

and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.

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

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

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

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

Section 10: Exclusions and Limitations

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

1. Addiction, such as:
   - Caffeine addiction.
   - Codependency.

   This exclusion does not apply to the Mental Illness and Substance Use Disorders benefits outlined in the Medical Expense Benefits section of the Policy.
2. Biofeedback.
3. Cosmetic procedures, except:
   - For reconstructive procedures that are:
     - Medically Necessary for the treatment of gender dysphoria.
     - To correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
5. Dental treatment, except:
   - For accidental Injury to Natural Teeth.
   - As described under Dental Treatment in the Policy.

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

   This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
8. Health spa or similar facilities. Strengthening programs.
9. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
   This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of an infection or Injury.

- A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

10. Hirsutism. Alopecia.
11. Hypnosis.
12. Injury or Sickness for which benefits are paid:
    - Under any Workers' Compensation or occupational Disease Law or Act, or similar legislation.
13. Investigational services.
14. Lipectomy.
15. Commission of or attempt to commit a felony.
16. Prescription Drug Services – no benefits will be payable for:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
    - Immunization agents, except as specifically provided in the Policy.
    - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Fertility agents, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
17. Reproductive services for the following:
    - Genetic counseling and genetic testing, except for the prenatal diagnosis of fetal genetic disorders.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Fertility tests.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
18. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.
19. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To benefits specifically provided in the Policy.
    - To eye examinations, including preventive screenings, for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.
20. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy. This exclusion does not apply to the Preventive Care Services benefits outlined in the Medical Expense Benefits section of the Policy.
21. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
22. Speech therapy, except as specifically provided in the Policy. Naturopathic services.
23. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
    This exclusion does not apply to the Preventive Care Services benefits outlined in the Medical Expense Benefits section of the Policy.
24. Supplies, except as specifically provided in the Policy.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
27. War or any act of war, declared or undeclared; while serving in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
28. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

Section 11: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

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

Submit the above information to the Company by mail:

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

Section 12: General Provisions

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

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

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid upon receipt of due written proof of such loss.

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

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

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

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

THIRD PARTY RECOVERY: If an Insured recovers money from a third party or third party insurer for medical expenses incurred due to an Injury or Sickness for which the Company paid a medical benefit, the Company must be repaid. The amount repaid will not exceed the amount allowed under California law. The Insured shall execute and deliver such instruments and papers as may be required, and do whatever else is necessary to secure such third party recovery rights to the Company. The Company will not prejudice the rights of the Insured.

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

Section 13: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

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

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

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

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

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

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

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

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

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

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

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

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

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

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

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
   a. The date of service;
   b. The name health care provider; and
   c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
   d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
   e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
   f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. A copy of the forms necessary to request the External Independent Medical Review;
7. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
8. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

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

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:
1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

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

Expedited Internal Review Process
The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:
1. Involving Urgent Care Requests; and
2. Related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received emergency services, but has not been discharged from a facility.

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

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

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

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

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

RIGHT TO EXTERNAL INDEPENDENT MEDICAL REVIEW

An Insured Person has the right to seek an External Independent Medical Review when health care services have been denied, modified, or delayed by the Company, if the decision was based in whole or in part on a finding that the proposed health care services are not Medically Necessary or are not Covered Medical Expense benefits under the Insured's Policy. An Insured Person may designate an Authorized Representative to act on his or her behalf. The Insured's Physician may join with or otherwise assist the Insured in seeking an External Independent Medical Review, and may advocate on behalf of the Insured.

The Insured Person may apply to the Department of Insurance for an External Independent Medical Review when all of the following conditions are met:

1. a. the Insured's Physician has recommended a health care service as Medically Necessary, or
   b. The Insured received Urgent Care or emergency services that a Physician determined were Medically Necessary, or
   c. The Insured, in the absence of a Physician recommendation under subparagraph 1a or the receipt of Urgent Care or emergency services by a Physician under subparagraph 1b has been seen by a Physician for the diagnosis or treatment of the medical condition for which the Insured seeks External Independent Medical Review.
2. The disputed health care service has been denied, modified, or delayed by the Company, based in whole or in part on a decision that the health care service is not Medically Necessary or is not a Covered Medical Expense benefit under the Policy that applies to the Insured.
3. The Insured has filed an Internal Appeal Review request with the Company, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The Insured shall not be required to participate in the Company's Internal Appeal process for more than 30 days. In the case of an Internal Appeal that requires expedited review, the Insured shall not be required to participate in the Company's Internal Appeal process for more than three days.

The External Independent Medical Review Process

An Insured Person may apply to the Department for an External Independent Medical Review of a Final Adverse Benefit Determination to deny, modify, or delay health care services based, in whole or in part, on a finding that the disputed health care services are not Medically Necessary, or are not a covered benefit under the Policy that applies to the Insured. The Insured's request for an External Independent Medical Review must be submitted to the Department within six months after the Insured receives the Final Adverse Benefit Determination notice. However, the Commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

As part of its notification to the Insured regarding a disposition of the Insured's Final Adverse Benefit Determination that denies, modifies, or delays health care services, the Company shall provide the Insured with an application form approved by the Department, and an addressed envelope, which the Insured may return to initiate an External Independent Medical Review.

Upon receipt of a notice from the Department that the Insured has applied for an External Independent Medical Review, the Company shall, within three business days, provide all the following documents to the Independent Medical Review Organization designated by the Department:

1. a. A copy of all of the Insured's medical records in the possession of the insurer relevant to each of the following:
      (i) The Insured's medical condition.
      (ii) The health care services being provided by the Physician for the condition.
      (iii) The disputed health care services requested by the Insured for the condition.
   b. Any relevant medical records kept by the Company or Physician and discovered or developed after the initial documents were provided to the Independent Medical Review Organization shall be forwarded immediately to the Independent Medical Review Organization. The Company shall concurrently offer to send copies of this

documentation to the Insured or, with the Insured's permission, to the Insured's Physician, unless the Insured declines such an offer or the offer is prohibited by law. The documents shall remain confidential as required by state and federal law.

c. Copies of all information the Company or Physician provided to the Insured regarding the Company's or Physician's decisions regarding the Insured's care or condition, including the Company's written response to the Insured's Internal Appeal.
d. Copies of all information the Insured or the Insured's Physician provided to the Company in support of the Insured's request for the disputed health care services.
e. Any other relevant documents or information used by the Company in determining whether disputed health care services should have been provided. The Company shall concurrently send copies of this documentation to the Insured and the Insured's Physician unless the Commissioner finds the material to be legally privileged. The Department and the Independent Medical Review Organization shall maintain the confidentiality of all documents found by the Commissioner to be proprietary information.
f. Any statements by the Company explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of Medical Necessity or not being a Covered Medical Expense benefit under the Policy. The Company shall concurrently send copies of this documentation to the Insured and the Insured's Physician unless the Commissioner finds the material to be legally privileged. The Department and the Independent Medical Review Organization shall maintain the confidentiality of all documents found by the Commissioner to be proprietary information.

2. Upon submitting all the necessary documents to the Independent Medical Review Organization, the Company shall:
   a. Provide the Insured with an annotated list of all documents submitted.
   b. Offer to provide copies to the documents, upon request from the Insured.
3. The Independent Medical Review Organization's reviewer must decide the matter within 30 days of receiving the application and supporting documents. The Department may extend this by 3 days in extraordinary circumstances or for good cause.
4. The Independent Medical Review Organization must provide its reviewer's analysis and determinations and a description of the reviewer's qualifications to the Commissioner, the Company, the Insured, and the Insured's Physician.
5. The Commissioner's written decision to adopt the determination of the Independent Review Organization shall be binding on the Company and the Insured.
6. The cost of the External Independent Medical Review shall be borne by the Company.

Where to Send Requests for External Independent Medical Review
All requests for External Independent Medical Review shall be submitted to the state insurance department at the following address:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll-Free Consumer Hotline:1-800-927-HELP (4357) or 1-213-897-8921
TDD Number:1-800-482-4TDD (4833)
http://www.insurance.ca.gov

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

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

Adverse Determination means:

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

4. A rescission of coverage.

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

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

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

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

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:
1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or
2. In the opinion of a physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

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

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

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll-Free Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921
TDD Number: 1-800-482-4TDD (4833)
http://www.insurance.ca.gov

Section 14: Online Access to Account Information

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

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

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

Section 15: ID Cards

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

Section 16: UHCSR Mobile App

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

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

Section 17: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

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

Sales/Marketing Services:
UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
E-mail:info@uhcsr.com

Customer Service:
800-767-0700
(Customer Services Representatives are available Monday - Friday,7:00 a.m. – 7:00 p.m.(Central Time))

Section 18: Pediatric Dental Services Benefit

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

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

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

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

Covered Dental Services

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

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

Pre-Treatment Estimate

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

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

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

Pre-Authorization

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

Section 2: Benefits for Pediatric Dental Services

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

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

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

Network Benefits:

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

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

Non-Network Benefits:

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

Dental Services Deductible

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

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

The Dental Services Deductible does not apply to *Diagnostic Services* and/or *Preventive Services*.

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

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

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

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

Benefit Description

Benefit Description and Limitations	**Network Benefits** **Benefits are shown as a percentage of Eligible Dental Expenses.**	**Non-Network Benefits** **Benefits are shown as a percentage of Eligible Dental Expenses.**
Diagnostic Services - (Not subject to payment of the Dental Services Deductible.)		
Evaluations (Checkup Exams) *Limited to 2 times per 12 months.* Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D0150 - Comprehensive oral evaluation D0170 - Re-evaluation - limited, problem focused	100%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D0180 - Comprehensive periodontal evaluation *The following service is not subject to a frequency limit.* D0160 - Detailed and extensive oral evaluation - problem focused		
Intraoral Radiographs (X-ray) *Limited to 2 series of films per 12 months.* D0210 - Complete series (including bitewings)	100%	50%
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first film D0230 - Intraoral - periapical - each additional film D0240 - Intraoral - occlusal film D0250 - Intraoral - occlusal film D0260 - Intraoral - occlusal film	100%	50%
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films D0277 - Vertical bitewings	100%	50%
The following services are covered when preformed in a dental setting. When services performed in a medical setting services are covered under the Insured's medical coverage. *Covered when medically necessary* D0310 - Sialography D0320 – Temporomandibular joint arthrogram, including injection D0322 - Tomographic survey *Limited to 1 time per 36 months.* D0330 - Panoramic radiograph image	100%	50%
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray D0350 - Oral/Facial photographic images D0391 - Interpretation of diagnostic images D0470 - Diagnostic casts	100%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D0502 - Other oral pathology procedures, by report D0999 - Unspecified diagnostic procedure, by report		
Preventive Services - (Not subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) *The following services are limited to 2 times every 12 months.* D1110 - Prophylaxis - adult D1120 - Prophylaxis – child	100%	50%
Fluoride Treatments *The following services are limited to 2 times every 12 months.* D1206 and D1208 - Fluoride	100%	50%
Sealants (Protective Coating) *The following services are limited to once per first or second permanent molar every 36 months.* D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	100%	50%
Space Maintainers (Spacers) *The following services are not subject to a frequency limit.* D1510 - Space maintainer - fixed - unilateral D1515 - Space maintainer - fixed - bilateral D1520 - Space maintainer - removable - unilateral D1525 Space maintainer - removable bilateral D1550 - Re-cementation of space maintainer D1555 - Removal of fixed space maintainer	100%	50%
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings) *The following services are not subject to a frequency limit.* D2140 - Amalgams - one surface, primary or permanent	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent		
Composite Resin Restorations (Tooth Colored Fillings) *The following services are not subject to a frequency limit.* D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior D2390 - Resin-based composite crown, anterior D2391 - Resin-based composite - one surface, posterior D2392 - Resin-based composite - two surfaces, posterior D2393 - Resin-based composite - three surfaces, posterior D2394 - Resin-based composite - four or more surfaces, posterior	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
The following services are subject to a limit of 1 time every 36 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four surfaces D2710 - Crown - resin-based composite (indirect) D2712 - Crown - 3/4 resin based composite (indirect) D2721 - Crown - resin with predominantly base metal D2740 - Crown - porcelain/ceramic substrate D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2780 - Crown - 3/4 case high noble metal	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 Crown – titanium D2929 – Prefabricated porcelain crown - primary D2930 Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth D2932 - Prefabricated resin crown D2933 - Prefabricated stainless streel crown with resin window *The following services are not subject to a frequency limit.* D2510 Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement inlay D2920 - Re-cement crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following service is limited to 1 time per tooth every 60 months. D2950 - Core buildup, including any pins	50%	50%
The following service is limited to 1 time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to Crown	50%	50%
The following service is not subject to a frequency limit. D2952 - Cast post and core in addition to crown D2954 - Prefabricated post and core in addition to crown D2970 - Temporary crown (fractured tooth)	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 – Inlay repair	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D2982 – Onlay repair D2983 – Veneer repair D2990 – Resin infiltration/smooth surface		
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration)	50%	50%
The following service is not subject to a frequency limit. D3221 - pulpal debridement, primary and permanent teeth D3222 - Partial pulpotomy for Apexogenesis - Permanent tooth with incomplete root development	50%	50%
The following services are not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior. primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit. D3310 - Anterior root canal (excluding final restoration) D3320 - Bicuspid root canal (excluding final restoration) D3330 - Molar root canal (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar	50%	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification - interim medication replacement D3353 - Apexification/recalcification - final visit	50%	50%
The following service is not subject to a frequency limit. D3354 - Pulpal Regeneration	50%	50%
The following services are not subject to a frequency limit.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root		
The following service is not subject to a frequency limit. D3450 - Root amputation - per root	50%	50%
The following service is not subject to a frequency limit. D3920 - Hemisection (including any root removal), not including root canal therapy D3999 - Unspecified endodontic procedure, by report	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more teeth D4211 - Gingivectomy or gingivoplasty - one to three teeth D4212 - Gingivectomy or gingivoplasty – with restorative procedures – per tooth	50%	50%
The following services are limited to 1 every 36 months. D4240 - Gingival flap procedure, four or more teeth D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following service is not subject to a frequency limit. D4249 - Clinical crown lengthening - hard tissue	50%	50%
The following services are limited to 1 every 36 months. D4260 - Osseous surgery D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant D4263 - Bone replacement graft – first site in quadrant	50%	50%
The following services are not subject to a frequency limit.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D4270 - Pedicle soft tissue graft procedure D4271 - Free soft tissue graft procedure		
The following services are not subject to a frequency limit. D4273 - Subepithelial connective tissue graft procedures, per tooth D4275 - Soft tissue allograft D4277 - Free soft tissue graft - first tooth D4278 - Free soft tissue graft - additional teeth	50%	50%
The following services are limited to 1 time per quadrant every 24 months. D4341 - Periodontal scaling and root planning - four or more teeth per quadrant D4342 - Periodontal scaling and root planning - one to three teeth per quadrant	50%	50%
The following service is limited to a frequency to 1 per lifetime. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis	50%	50%
The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance *The following service is not subject to a frequency limit.* D4920 - Unscheduled dressing change (by someone other than treating dentist or their staff) D4999 - Unspecified periodontal procedure, by report	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 36 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Mandibular partial denture - resin base	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D5212 - Maxillary partial denture - resin base D5213 - Maxillary partial denture - cast metal framework with resin denture base D5214 - Mandibular partial denture - cast metal framework with resin denture base D5281 - Removable unilateral partial denture - one piece cast metal		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5510 - Repair broken complete denture base D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5620 - Repair cast framework D5630 - Repair or replace broken clasp D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture	50%	50%
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5730 - Reline complete maxillary denture D5731 - Reline complete mandibular denture D5740 - Reline maxillary partial denture D5741 - Reline mandibular partial denture D5750 - Reline complete maxillary denture (laboratory)	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D5751 - Reline complete mandibular denture (laboratory) D5752 - Reline complete mandibular denture (laboratory) D5760 - Reline maxillary partial denture (laboratory) D5761 - Reline mandibular partial denture (laboratory) - rebase/reline D5762 - Reline mandibular partial denture (laboratory)		
The following services are not subject to a frequency limit. D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
The following service is limited to 1 time per tooth every 60 months. D5860 - Overdenture - complete, by report	50%	50%
The following services are not subject to a frequency limit. D5899 - Unspecified removable prosthodontic procedure, by report	50%	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - case high noble metal D6211 - Pontic - case predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6245 - Pontic - porcelain/ceramic	50%	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are not subject to a frequency limit. D6519 - Inlay/onlay - porcelain/ceramic D6520 - Inlay - metallic - two surfaces	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D6530 - Inlay - metallic - three or more surfaces D6543 - Onlay - metallic - three surfaces D6544 - Onlay - metallic - four or more surfaces		
The following services are limited to 1 time every 60 months. D6740 - Crown - porcelain/ceramic D6750 - Crown - porcelain fused to high noble metal D6751 - Crown - porcelain fused to predominately base metal D6752 - Crown - porcelain fused to noble metal D6780 - Crown - 3/4 cast high noble metal D6781 - Crown - 3/4 cast predominately base metal D6782 - Crown - 3/4 cast noble metal D6783 - Crown - 3/4 porcelain/ceramic D6790 - Crown - full cast high noble metal D6791 - Crown - full cast predominately base metal D6792 - Crown - full cast noble metal	50%	50%
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond fixed partial denture	50%	50%
The following services are not subject to a frequency limit. D6973 - Core build up for retainer, including any pins D6980 - Fixed partial denture repair necessitated by restorative material failure D6999 - Unspecified, fixed prosthodontic procedure, by report	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit. D7111 - Extraction, coronal remnants - deciduous tooth D7140 - Extraction, erupted tooth or exposed root	50%	50%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring elevation of	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
mucoperioteal flap and removal of bone and/or section of tooth D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - complete bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal D7260 - Oroantral fistula closure - upper molar tooth; extract the tooth - create an opening between sinus D7261 - Primary closure of a sinus perforation		
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth D7283 - Placement of a device to facilitate eruption of impacted tooth D7290 - Surgical repositioning of teeth	50%	50%
The following service is limited to 3 per site per visit. D7286 - Incisional biopsy of oral tissue - soft	50%	50%
The following service is limited to 1 per arch per lifetime. D7291 – Transseptal fiberotomy/supra crestal fiberotomy, by report	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - per quadrant	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant		
The following service is not subject to a frequency limit. D7471 - removal of lateral exostosis (maxilla or mandible) D7472 - Removal of torus palatinus D7485 - Surgical reduction of osseous tuberosity	50%	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess D7511 - Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) D7520 - Incision and drainage of abscess - extraoral soft tissue D7521 - Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) D7910 - Suture of recent small wounds up to 5 cm D7921 - Collect - apply autologous product D7953 - Bone replacement graft for ridge preservation - per site D7971 - Excision of pericoronal gingiva	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure D9120 - Fixed partial denture sectioning	50%	50%
Covered only when clinically Necessary. D9220 - Deep sedation/general anesthesia first 30 minutes D9221 - Dental sedation/general anesthesia each additional 15 minutes	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D9230 - Inhalation of nitrous oxide/analgesia, anxiolysis D9241 - Intravenous conscious sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9248 - Non-intravenous moderate (conscious) sedation D9430 - Office visit for observation (during regularly scheduled hours) - no other services performed D9610 - Therapeutic drug injection, by report D9910 - Application of desensitizing medicament D9930 - Treatment of complications (post-surgical) - unusual circumstances, by report D9999 - Unspecified adjunctive procedure, by report		
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	50%	50%
The following is limited to 1 guard every 12 months. D9940 - Occlusal guard D9950 - Occlusion analysis - mounted case D9951 - Occlusal adjustment - limited D9952 - Occlusal adjustment - complete	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to 1 time every 60 months. D6010 - Endosteal implant D6012 - Surgical placement of interim implant body D6040 - Eposteal Implant D6050 - Transosteal implant, including hardware D6053 - Implant supported complete denture D6054 - Implant supported partial denture D6055 - Connecting bar implant or abutment supported D6056 - Prefabricated abutment D6057 - Custom abutment D6058 - Abutment supported porcelain ceramic crown	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D6059 - Abutment supported porcelain fused to high noble metal D6060 - Abutment supported porcelain fused to predominately base metal crown D6061 - Abutment supported porcelain fused to noble metal crown D6062 - Abutment supported cast high noble metal crown D6063 - Abutment supported case predominately base metal crown D6064 - Abutment supported porcelain/ceramic crown D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported porcelain fused to high metal crown D6067 - Implant supported metal crown D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture D6072 - Abutment supported retainer for cast high noble metal fixed partial denture D6073 - Abutment supported retainer for predominately base metal fixed partial denture D6074 - Abutment supported retainer for cast metal fixed partial denture D6075 - Implant supported retainer for ceramic fixed partial denture D6076 - Implant supported retainer for porcelain fused to high noble metal fixed partial denture D6077 - Implant supported retainer for cast metal fixed partial denture D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch D6080 - Implant maintenance procedure D6090 - Repair implant prosthesis D6091 - Replacement of semi-precision or precision attachment	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D6092 - Re-cement or rebond implant/abutment supported crown D6093 - Re-cement or re-bond implant/abutment supported fixed partial denture D6095 - Repair implant abutment D6100 - Implant removal D6101 - Debridement periimplant defect D6102 - Debridement and osseous periimplant defect D6103 - Bone graft periimplant defect D6104 - Bone graft implant replacement D6190 - Implant index D6194 - Abutment supported retaininer crown for FPD - (titanium) D6199 - Unspecified implant procedure, by report	50%	50%
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for comprehensive orthodontic treatment are approved by the Company, when Necessary to promote oral health, restore oral structures to health and function, and to treat emergency conditions. Benefits are also provided for all medically handicapping malocclusions, regardless of cause, including Injury. All orthodontic treatment must be prior authorized.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8050 - Interceptive orthodontic treatment of the primary dentition D8060 - Interceptive orthodontic treatment of the transitional dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8691 - Repair of orthodontic appliance D8692 - Replacement of lost or broken retainer D8693 - Re-cement or re-bonding or re-cementing of fixed retainers	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D8999 - Unspecified orthodontic procedure, by report	50%	50%

IMPORTANT: If the Insured opts to receive Dental Services that are not Covered Dental Services under this policy, a Network Dental Provider may charge the Insured his or her Usual and Customary Fee for those services. Prior to providing an Insured with Dental Services that are not a covered benefit, the Dental Provider should provide the Insured with a treatment plan that includes each anticipated Dental Service to be provided and the estimated cost of each Dental Service. If the Insured would like more information about dental coverage options, the Insured may call *Customer Service* at 877-816-3596. To fully understand this coverage, the Insured may wish to carefully review this policy.

Section 3: Pediatric Dental Exclusions

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

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting, except as specifically provided in Dental Services in the Medical Expense Benefits section of the Policy.
7. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
8. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
9. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
10. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
11. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
12. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
13. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
14. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
15. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
16. Foreign Services are not covered unless required for a Dental Emergency.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
22. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

To file a claim, submit the above information to the Company at the following address:
UnitedHealthcare Dental
ATTN: Claims Unit
P. O. Box 30567
Salt Lake City, UT 84130-0567

If the Insured Person would like to use a claim form, call *Customer Service* at 1-877-816-3596. This number is also listed on the Insured's Dental ID Card. If the Insured Person does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

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

Covered Dental Service - a Dental Service or Dental Procedure for which benefits are provided under this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.

- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.

Pursuant to other appropriate source or determination that the Company accepts.

Section 19: Pediatric Vision Care Services Benefit

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Non-Network Benefits:

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

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

Policy Deductible

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

Benefit Description

Benefits

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

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

Frequency of Service Limits

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

Routine Vision Examination

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

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

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

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

Eyeglass Lenses

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

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

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

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose. The Insured Person is eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If the Insured Person selects more than one of these Vision Care Services, the Company will pay benefits for only one Vision Care Service.

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

Contact Lenses

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

Benefits include the fitting/evaluation fees and contacts.

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

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company.

Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision

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

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.
- Low Vision Aids: Prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes.
- Low Vision follow-up care.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• *Single Vision*		100% after a Copayment of $40.	50% of the billed charge.
• *Bifocal*		100% after a Copayment of $40.	50% of the billed charge.
• *Trifocal*		100% after a Copayment of $40.	50% of the billed charge.
• *Lenticular*		100% after a Copayment of $40.	50% of the billed charge.
Lens Extras	Once per year.		
• *Polycarbonate lenses*		100%	100% of the billed charge.
• *Standard scratch-resistant coating*		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
• *Eyeglass frames with a retail cost up to $130.*		100%	50% of the billed charge.
• *Eyeglass frames with a retail cost of $130 - $160.*		100% after a Copayment of $15.	50% of the billed charge.
• *Eyeglass frames with a retail cost of $160 - $200.*		100% after a Copayment of $30.	50% of the billed charge.
• *Eyeglass frames with a retail cost of $200 - $250.*		100% after a Copayment of $50.	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
• *Eyeglass frames with a retail cost greater than $250.*		60%	50% of the billed charge.
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
• *Necessary Contact Lenses*	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
Low Vision Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.		100% of the billed charge.	75% of the billed charge.
• Comprehensive low vision evaluation	Limited to once every 60 months.	100% of the billed charge.	75% of the billed charge.
• Low vision testing		100% of the billed charge.	75% of the billed charge.
• Low vision therapy		100% of the billed charge.	75% of the billed charge.
• Low vision aids		100% of the billed charge.	75% of the billed charge.
• Follow-up Care	Limited to 4 visits every 60 months.	100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company. Information about claim timelines and responsibilities in the General Provisions section in the Certificate of Coverage applies to Vision Care Services provided under this section, except that when the Insured Person submits a Vision Services claim, the Insured Person must provide the Company with all of the information identified below.

Reimbursement for Vision Care Services

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

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number from the ID card.
- Insured Person's date of birth.

Submit the above information to the Company:
By mail:
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):
248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

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

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

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

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

Section 20: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

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

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

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

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after ¾ of the original Prescription Drug Product has been used. For select controlled medications filled at a retail Network Pharmacy, refills are available when 90% of the original Prescription Drug Product has been used. For select controlled medications filled at a mail order Network Pharmacy, refills are available when 80% of the original Prescription Drug Product has been used.

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

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

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

Copayment and/or Coinsurance Amount

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

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

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

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

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

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Policy Schedule of Benefits. For a single Copayment and/or Coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

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

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

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject, from time to time, to the Company's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change. Therefore the Copayment and/or Coinsurance may change. The Insured will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug is assigned.

Designated Pharmacies

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

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

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

Prior Authorization Requirements

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

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

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

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

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

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

Step Therapy

Certain Prescription Drug Products for which benefits are provided are subject to step therapy requirements. In order to receive benefits for such Prescription Drug Products an Insured must use a different Prescription Drug Product(s) first.

Step therapy is a process whereby Prescription Drug Products or Pharmaceutical Products are filled with an effective, but more affordable medication. When appropriate, a more costly medication can be authorized if the Prescription Drug Product or Pharmaceutical Product is not effective in treating the Insured Person's condition. Step therapy is designed to encourage the use of cost-effective Prescription Drug Products or Pharmaceutical Products when appropriate.

If the Insured Person's Physician determines that a Prescription Drug Product or Pharmaceutical Product subject to the step therapy requirements is not medically appropriate or is not satisfactorily treating the Insured Person's condition, the Physician can request an exception to the step therapy process by contacting us at www.unitedhealthcareonline.com.

If the Insured Person is changing policies, we will not require the Insured Person to repeat step therapy when the Insured Person is already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for the Insured Person's medical condition. However, we may impose prior authorization requirements for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy requirements imposed by the former policy. The prescribing provider may also prescribe another Prescription Drug Product covered under this Policy that is medically appropriate for the Insured Person's medical condition.

The Insured may find out whether a particular Prescription Drug Product is subject to step therapy requirements at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

A request for an exception to the step therapy requirements may be submitted in the same manner as a request for prior authorization for Prescription Drug Products as described in the Prior Authorization Requirements section.

Medically Necessary antiretroviral drugs for the prevention of AIDS/HIV, including preexposure prophylaxis and postexposure prophylaxis, are not subject to step therapy requirements, except when the United States Food and Drug Administration has approved one or more Therapeutic Equivalents of a drug, device, or product for the prevention of AIDS/HIV. Not all Therapeutically Equivalent versions are required to be covered without step therapy, if at least one Therapeutically Equivalent version is covered without step therapy.

Limitation on Selection of Pharmacies

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person’s choice of Network Pharmacies may be limited. If this happens, the Company may require the Insured to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the chosen Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will choose a Network Pharmacy for the Insured.

Coverage Policies and Guidelines

The Company’s Prescription Drug List (PDL) Management Committee makes tier placement changes on the Company’s behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product’s total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

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

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

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

Rebates and Other Payments

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

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

Definitions

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician will be classified as Brand-name by the Company.

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

Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are a Designated Pharmacy.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

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

Exceptions:

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

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician will be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

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

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

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

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

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

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

- Inhalers.
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

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

Prescription Drug List means a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's review and change from time to time. The Insured may find out which tier a particular Prescription Drug Product has been placed at www.uhcsr.com or call *Customer Service* at 1-855-828-7716.

Prescription Drug List Management Committee means the committee that the Company designates for placing Prescription Drugs into specific tiers.

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

PPACA means Patient Protection and Affordable Care Act of 2010.

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

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

The Insured may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

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

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

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

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

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

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

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
   This exclusion does not apply to drugs approved by the U.S. Food and Drug Administration which are prescribed for either of the following:
   a. To treat cancer during certain clinical trials as described in the Policy.
   b. For a use that is different from the use for which the U.S. Food and Drug Administration approved it, when needed for treatment of a chronic and seriously debilitating or life-threatening condition. The drug must be recognized for the specific treatment for which the drug is being prescribed by any of the following:
      i. The American Hospital Formulary Service's Drug Information.
      ii. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
         - Elsevier Gold Standard's Clinical Pharmacology.
         - National Comprehensive Cancer network Drug and Biologics Compendium.
         - Thomson Microdex DrugDex.
      iii. It is recommended by two articles from major peer reviewed medical journals.

   This exception does not provide coverage for any drug that the U.S. Food and Drug Administration or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3.)

7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
   Over-the-counter drugs and devices prescribed by a Physician for preventive care services are provided as required under the Preventive Care Services benefit.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
11. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
12. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a “biosimilar” is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Durable medical equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
15. Diagnostic kits and products.
16. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
17. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.

Right to Request an Exclusion Exception

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

Urgent Requests

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

External Review

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

Expedited External Review

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

Schedule of Benefits

CALIFORNIA INSTITUTE OF THE ARTS

2020-756-1

METALLIC LEVEL - PLATINUM WITH ACTUARIAL VALUE OF 87.810%

Injury and Sickness Benefits

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

Deductible Preferred Provider	**$150 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network	**$500 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Provider	**80% except as noted below**
Coinsurance Out-of-Network	**60% except as noted below**
Out-of-Pocket Maximum Preferred Provider	**$5,000 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Provider	**$7,500 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$10,000 (Per Insured Person, Per Policy Year)**

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

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. Covered Medical Expense incurred at a Preferred Provider facility by an Out-of-Network Provider will be paid at the Preferred Provider level of benefits, except when agreed to in advance as stated in the Surprise Bills provision of the Certificate. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Student Health Center Benefits: Benefits will be paid at the Preferred Provider level of benefits for Covered Medical Expenses when treatment is rendered at the Student Health Center.

Out-of-Country Claims:

Covered Medical Expenses for services received outside the U.S. will be paid as follows:

- Emergency Services when due to a Medical Emergency will be paid at the Preferred Provider level of benefits.
- All other services will be paid at the Out-of-Network level of benefits.

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

Inpatient	Preferred Provider	Out-of-Network Provider
Room and Board Expenses	$50 Copay per Hospital Confinement 80% of Preferred Allowance not subject to Deductible	60% of Usual and Customary Charges after Deductible
Intensive Care	$50 Copay per Hospital Confinement 80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Hospital Miscellaneous Expenses	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Assistant Surgeon Fees	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Anesthetist Services	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Private Duty Nurse's Services	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Physician's Visits	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Day Surgery Miscellaneous	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Assistant Surgeon Fees	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Anesthetist Services	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Physician's Visits	$20 Copay per visit 100% of Preferred Allowance not subject to Deductible	60% of Usual and Customary Charges after Deductible

Outpatient	Preferred Provider	Out-of-Network Provider
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$150 Copay per visit 80% of Preferred Allowance not subject to Deductible	$150 Copay per visit 80% of Usual and Customary Charges not subject to Deductible (The Insured's expense shall not exceed the amount payable for Preferred Provider Medical Emergency Expenses.)
Diagnostic X-ray Services	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Radiation Therapy	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Laboratory Procedures	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Tests & Procedures	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Injections	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Chemotherapy	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Prescription Drugs	*UnitedHealthcare Pharmacy (UHCP) $10 Copay per prescription Tier 1 $30 Copay per prescription Tier 2 $50 Copay per prescription Tier 3 up to a 30-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay and/or Coinsurance (up to 50% of the Prescription Drug Charge). Mail order prescription drugs are available at 2.5 times the retail Copay up to a 90-day supply.	$10 Copay per prescription generic drug $30 Copay per prescription brand-name drug up to a 30-day supply per prescription not subject to Deductible

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	80% of Preferred Allowance after Deductible	80% of Usual and Customary Charges after Deductible (The Insured's air ambulance expense shall not exceed the amount payable for Preferred Provider air ambulance services.)
Durable Medical Equipment See also Benefits for Prosthetic Devices for Speaking Post Laryngectomy in the Mandated Benefits Section of the Certificate	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Consultant Physician Fees	$20 Copay per visit 100% of Preferred Allowance not subject to Deductible	60% of Usual and Customary Charges after Deductible
Dental Treatment Benefits paid on Injury to Natural Teeth or as specifically provided in the Certificate only.	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Mental Illness Treatment See also Benefits for Severe Mental Illnesses and Serious Emotional Disturbances in the Mandated Benefits Section of the Certificate	**Inpatient:** $50 Copay per Hospital Confinement 80% of Preferred Allowance after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Preferred Allowance not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 80% of Preferred Allowance after Deductible	**Inpatient:** 60% of Usual and Customary Charges after Deductible **Outpatient office visits:** 60% of Usual and Customary Charges after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Usual and Customary Charges after Deductible
Substance Use Disorder Treatment	**Inpatient:** $50 Copay per Hospital Confinement 80% of Preferred Allowance after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Preferred Allowance not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 80% of Preferred Allowance after Deductible	**Inpatient:** 60% of Usual and Customary Charges after Deductible **Outpatient office visits:** 60% of Usual and Customary Charges after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Usual and Customary Charges after Deductible
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible

Other	Preferred Provider	Out-of-Network Provider
Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	60% of Usual and Customary Charges after Deductible
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes in the Mandated Benefits Section of the Certificate	Paid as any other Sickness	Paid as any other Sickness
Home Health Care 100 visits maximum per Policy Year	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Hospice Care	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Inpatient Rehabilitation Facility	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Skilled Nursing Facility	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Urgent Care Center	$20 Copay per visit 80% of Preferred Allowance not subject to Deductible	60% of Usual and Customary Charges after Deductible
Hospital Outpatient Facility or Clinic	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Acupuncture Services	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Medical Foods See also Benefits for Phenylketonuria in the Mandated Benefits Section of the Certificate.	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Ostomy and Urological Supplies	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible
Vision Correction	80% of Preferred Allowance after Deductible	60% of Usual and Customary Charges after Deductible

NON-DISCRIMINATION NOTICE

UnitedHealthcare **Student**Resources 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

We 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 toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee
ᏕᎦᏅᏍᎬᎢ ᎤᏅᏌᏛᎦᏍᏓ ᎤᏅᏌᏈᎬᎢ ᏂᏍ ᎡᎶᎯᏅᎢᏍᏓᏗᎸᎢ ᏂᏓᎬᏩᎶᏫ ᎠᏎᏫᎢ. ᎰᏩᏫ ᎠᏂ ᏫᏏᎳᏛᏕ 1-866-260-2723.

Chinese
您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho̱ chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo
Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole
Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German
Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

Hawaiian
Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong
Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo
Enyemaka na-ahazi asụsụ, bu n’efu, dịrị gị. Kpọọ 1-866-260-2723.

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian
Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
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 までお電話ください。

Karen
ကိုဒ်တၢ်မၤစၢၤအၢ်ကိ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိဉ်ဟ့ဉ်အပူၤဘဉ်(ခီလီ)နူဉ်လီၤ. ဝံသးစူၤဆဲးကျိးဘဉ်1-866-260-2723တက့ၢ်.

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani
خزمەتەکانی یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

Laotian
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi
भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeļok wōņāān. Jouj im kaļļok 1-866-260-2723.

Micronesian- Pohnpeian
Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo
Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shǫǫdí kohjį' 1-866-260-2723 hodíilnih.

Nepali
भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka
Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn cɔl 1-866-260-2723.

Norwegian
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

Polish
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa
O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde
E woodi walliinde dow wolde caahu ngam maaɗa. Noodu 1-866-260-2723.

Swahili
Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
ܚܕ̈ܡܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܨܛܡܚܢܝܬܐ، ܐܝܬ ܠܟܘܢ ܡܓܢ. ܒܒܥܘܬܐ، ܩܪܘ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

Tagalog
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 1-866-260-2733

Tongan- Fakatonga
'Oku 'i ai pē 'a e sēvesi ki he lea' ke tokoni kiate koe pea 'oku 'atā ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

Ukrainian
Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 1-866-260-2723 پر کال کریں۔

Vietnamese
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddish
שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba
Isẹ̀ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.

POLICY NUMBER: 2020-756-1

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.

NOC1 - 09/25/2020
Correcting the Mental Illness Treatment/Substance Use Disorder Treatment OON benefits
From:
Inpatient:
60% of Preferred Allowance
after Deductible

Outpatient office visits:
60% of Preferred Allowance
after Deductible

All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:
60% of Preferred Allowance
after Deductible

To:
Inpatient:
60% of Usual and Customary Charges
after Deductible

Outpatient office visits:
60% of Usual and Customary Charges
after Deductible

All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:
60% of Usual and Customary Charges
after Deductible