UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT INJURY AND SICKNESS INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the International Students of

WESTERN KENTUCKY UNIVERSITY

2021-2022

This Certificate of Coverage is Part of Policy # 2021-1644-4

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

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

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

UnitedHealthcare®

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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/wku. 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 international students, include ESL, F-1, J1, visiting faculty and scholars are automatically enrolled in the plan at registration, unless proof of comparable coverage is provided.

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 30 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

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

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse or 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., August 1, 2021. 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., July 31, 2022. 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.

If paying premium by semester, coverage expires as follows:

Fall	8/1/2021	to	12/31/2021
Spring/Summer	1/1/2022	to	7/31/2022
Summer	5/4/2022	to	7/31/2022

The Insured Person must meet the eligibility requirements each time a premium payment is made. A Grace Period provision is included in the General Provisions section. To avoid a lapse in coverage, the Insured Person's premium must be received within 30 days after the coverage expiration date. It is the Insured Person's responsibility to make timely premium payments to avoid a lapse in coverage.

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

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Totally Disabled and/or 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 12 months after the Termination Date.

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

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

Section 4: Pre-Admission Notification

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

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

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

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

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

Section 5: Preferred Provider Information

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

UnitedHealthcare 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/wku. 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 UnitedHealthcare 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.

Section 6: Medical Expense Benefits – Injury and Sickness

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

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

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

Inpatient

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

2. **Intensive Care.**
   If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.

- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

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

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

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

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

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

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

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

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

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

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

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

Outpatient

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

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

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

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

15. **Physician's Visits.**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery or Physiotherapy.

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

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

Any visit limits for physical therapy, occupational therapy, and speech therapy specified in the Schedule of Benefits does not apply to the treatment of autism spectrum disorder.

Any Copay or Coinsurance for each day of service for services rendered by a physical therapist or an occupational therapist shall be no greater than the Copay or Coinsurance amount charged to an Insured for a Physician's office visit.

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.**
Radiation therapy received on an outpatient basis. Benefits include the following:
- Therapeutic treatment.
- Related supplies and equipment.

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.**
Chemotherapy treatment received on an outpatient basis. Benefits include the following:
- Therapeutic treatment.
- Related supplies and equipment.

24. **Prescription Drugs.**
Prescription Drugs not dispensed or purchased while confined as an Inpatient. See Schedule of Benefits.

Other

25. **Ambulance Services.**
Ambulance services include transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured.

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

For the purposes of this benefit, the following are considered durable medical equipment.
- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part.

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

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

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

Benefits will also be provided the same as any other Sickness for the Hospital or facility charges and anesthesia services performed in a Hospital in connection with dental procedures for the following:
- An Insured Dependent child under the age of 9.
- An Insured Person with serious mental or physical conditions.
- An Insured Person with significant behavioral problems.
- An Insured Person whose medical condition or dental procedure requires a Hospital setting to ensure the Insured's safety. This does not include benefits for the dental procedure.

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

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

29. **Mental Illness Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

30. **Substance Use Disorder Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

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

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

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

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

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

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

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

36. **Home Health Care.**
See Benefits for Home Health Care under the Mandated Benefits section of the Policy.

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

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

Hospice care benefits are not subject to the Policy Deductible.

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

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

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

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

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

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

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

42. **Approved Clinical Trials.**
Routine Patient Care Costs incurred while taking part 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.

"Approved clinical trial" also means a phase I, phase II, or phase III clinical trial that is conducted in relation to the detection of such non-life-threatening disease or disorder such as cardiovascular disease or musculoskeletal disorders of the spine, hip and knees, and other diseases or disorders which are not life threatening.

An Approved Clinical Trial needs to meet any of the following criteria listed below:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The Company may, at any time, request documentation about the trial.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Medical Expense and is not otherwise excluded under the Policy.

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

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

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

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

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

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits include the hearing aid, and charges for associated fitting and testing. If more than one type of hearing aid can meet the Insured's functional needs, benefits are available only for the hearing aid that meets the minimum specifications for the Insured's needs. Benefits are limited to one hearing aid per hearing impaired ear every 36 months.

46. **Medical Foods.**
Benefits are payable for therapeutic food, formulas, supplements (including vitamins and nutritional supplements), amino acid-based elemental formula, and low-protein modified food products for the treatment of inborn errors of metabolism or genetic (including mitochondrial disease), gastrointestinal, and food allergic conditions. Medical foods must be prescribed by a Physician. The written prescription must accompany the claim when submitted.

47. **Ostomy Supplies.**
Benefits for ostomy supplies are limited to the following supplies:
- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

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

48. **Wigs**.
Wigs and other scalp hair prosthesis as a result of hair loss due to cancer treatment. Benefits are limited to one wig per Policy Year.

Section 7: Mandated Benefits

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Sickness for low-dose mammography screening according to the following guidelines:
1. One screening mammogram to women age thirty-five through thirty-nine.
2. One mammogram every 2 years for women age forty through forty-nine.
3. One mammogram per year for women age fifty years of age and over.

Benefits shall also provide coverage for mammograms, performed on dedicated equipment that meets the guidelines established by the American College of Radiology, for any Insured Person, regardless of age, who has been diagnosed with breast disease upon referral by a health care practitioner acting within the scope of his or her licensure.

"Mammography" means an x-ray examination of the breast using equipment dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film and cassettes, with two views of each breast and with an average radiation exposure at the current recommended level as set forth in guidelines of the American College of Radiology, and digital mammography including breast tomosynthesis.

"Breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

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

BENEFITS FOR BONE MARROW TRANSPLANTS FOR TREATMENT OF BREAST CANCER

Benefits will be paid the same as any other Sickness for the treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation.

The administration of high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation shall only be covered when performed in an institution that complies with the guidelines of the American Society for Blood and Marrow transplantation or the International Society of Hematotherapy and Graft Engineering, whichever has the higher standard.

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

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER

Benefits will be paid the same as for treatment to any other joint in the body for Medically Necessary surgical and non-surgical treatment of temporomandibular joint disorder and craniomandibular jaw disorder. Treatment may be administered or prescribed by a Physician or dentist**.**

Benefits do not include dental services not otherwise covered under the Policy.

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

BENEFITS FOR HOME HEALTH CARE

Benefits will be paid for the Covered Medical Expenses incurred as specified in the Schedule of Benefits for home health care visits. Each visit by an authorized representative of a home health agency shall be considered as one (1) home health care visit except that at least four (4) hours of home health aide service shall be considered as one (1) home health visit.

Home health care shall not be reimbursed unless an attending Physician certifies that hospitalization or confinement in a Skilled Nursing Facility as defined by the Kentucky health facilities and health services certificate of need and licensure board would otherwise be required if home health care was not provided.

Benefits shall also include an additional 250 maximum visits for Private Duty Nursing. For the purposes of this benefit "private duty nursing" means skilled nursing service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.) or licensed practical nurse (L.P.N). Private duty nursing is shift nursing of eight (8) hours or greater per day and does not include nursing care of less than eight (8) hours per day. Private duty nursing does not include Custodial Care service.

Medicare beneficiaries shall be deemed eligible to receive home health care benefits under this policy provided that the policy shall only pay for those home health care services which are not paid for by Medicare and do not exceed the maximum liability of the Policy.

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

BENEFITS FOR BONE DENSITY TESTING FOR OSTEOPOROSIS DETECTION

Benefits will be paid the same as any other Sickness for bone density testing for women age thirty-five (35) and older, as indicated by the Physician, in accordance with standard medical practice, to obtain baseline data for the purpose of early detection of osteoporosis.

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

BENEFITS FOR INHERITED METABOLIC DISEASES OF NEWBORN INFANT

Benefits will be paid the same as any other Prescription Drug for a one hundred percent (100%) human diet, if the diet and supplemented milk fortifier products are prescribed and administered under the direction of a Physician for the prevention of Necrotizing Enterocolitis and associated comorbidities.

"Milk fortifier" means a commercially prepared human milk fortifier made from concentration of hundred percent human milk.

"One hundred percent (100%) human diet" means the supplementation of a mother's expressed breast milk or donor milk with a milk fortifier.

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

BENEFITS FOR PRESCRIPTION EYE DROPS

Benefits will be paid the same as any other Prescription Drug for prescription eye drops as specified below.

The prescription eye drop refill will be covered if:

1. The refill is requested by the insured:
   - For a thirty (30) day supply, between twenty-five (25) days and thirty (30) days from the later of:
     - The original date the prescription was dispensed to the Insured.
     - The date the most recent refill was dispensed to the Insured.
   - For a ninety (90) day supply, between eighty (80) days and ninety (90) days from the later of:
     - The original date the prescription was dispensed to the Insured.
     - The date the most recent refill was dispensed to the Insured.
2. The prescribing Physician indicates on the original prescription that additional quantities are needed and the Insured's refill request does not exceed the number of additional quantities needed.

Benefits include one (1) additional bottle of prescription eye drops when:

1. The additional bottle is requested by the Insured or the prescribing Physician at the time the original prescription is distributed to the Insureds.
2. The prescribing Physician indicates on the original prescription that the additional bottle is needed by the Insured for use in a day care center or school.
3. Benefits for an additional bottle shall be limited to one (1) bottle every three (3) months.

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

BENEFITS FOR ANTICANCER MEDICATIONS

Benefits for patient-administered anticancer medications, including orally administered or self-injected medications, will be paid on a basis no less favorable than intravenously administered or injected cancer medications administered by a Physician.

The cost sharing shall not exceed one hundred dollars ($100) per prescription for a thirty (30) day supply.

In all other respects, benefits shall be subject to all limitations or any other provisions of the Policy.

BENEFITS FOR TELEHEALTH SERVICES

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

"Telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

Benefits shall not be provided if the telehealth consultation is provided through the use of an audio-only telephone, facsimile, text chat, or electronic mail.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Except as noted below, benefits will be paid the same as any other Sickness for colorectal cancer examinations and laboratory tests specified in the most recent version of the American Cancer Society guidelines for complete colorectal cancer screening of asymptomatic individuals as follows:

1. Benefits shall be provided for all colorectal screening exams and tests that are administered at a frequency identified in the American Cancer Society guidelines for complete colorectal cancer screening.
2. The Insured shall be:
   - Forty-five (45) years of age or older.
   - Less than forty-five (45) years of age and at high risk for colorectal cancer according to the most recent version of the American Cancer Society guidelines for complete colorectal cancer screening.

Colorectal cancer screenings performed by a Preferred Provider shall not be subject to a Deductible or Coinsurance. Colorectal cancer screenings performed by a Preferred Provider shall be subject to all limitations or any other provisions of the Policy.

Colorectal cancer screenings performed by an Out-of-Network Provider shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR ENDOMETRIOSIS AND ENDOMETRITIS

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of endometriosis and endometritis.

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

BENEFITS FOR TOBACCO CESSATION SERVICES

Benefits will be paid the same as any other Sickness for tobacco cessation services including all United States Food and Drug Administration approved tobacco cessation medications (prescription and over-the-counter), all forms of tobacco cessation services recommended by the *United States Preventive Services Task Force*, including but not limited to individual, group, and telephone counseling, and any combination thereof.

There are no counseling requirements in order to obtain tobacco cessation medications and there are no annual or lifetime limits on the number of covered attempts to quit.

Utilization management requirements may only be required for treatment that exceeds the duration recommendation by the most recently published United States Public Health Service clinical practice guidelines on treating tobacco use and dependence, or for services associated with more than 2 attempts to quit within a 12-month period.

Benefits shall not be subject to a Deductible, Copayment or Coinsurance, but are subject to all limitations or any other provisions of the Policy.

BENEFITS FOR GENETIC TESTS FOR CANCER RISK

Except as noted below, benefits will be paid the same as any other Sickness for Genetic Tests for Cancer Risk recommended by a Kentucky licensed Physician if the recommendation is consistent with the most recent version of genetic testing guidelines published by the National Comprehensive Cancer Network (NCCN).

"Genetic test for cancer risk" means a blood, saliva, or tissue typing test that reliably determines the presence or absence of an inherited genetic characteristic that is generally accepted in the medical or scientific community as being associated with a statistically significant increased risk of cancer development.

Genetic Tests for Cancer Risk performed by a Preferred Provider shall not be subject to a Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Genetic Tests for Cancer Risk performed by an Out-of-Network Provider shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Benefits will be paid at the Preferred Provider level of benefits for Out-of-Network Providers if there are no Preferred Providers available to provide the covered test.

Section 8: Coordination of Benefits Provision

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

Definitions

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

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

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

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

   Plan includes all of the following:
   - Group insurance contracts and subscriber contracts.
   - Uninsured arrangements of group or group-type coverage.
   - Group coverage through closed panel Plans.
   - Group-type contracts, including blanket contracts.
   - The medical care components of long-term care contracts, such as skilled nursing care.
   - 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.
   - Any health benefit plan which includes any hospital medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky Insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky.

   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.
   - The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.

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.

8. **Noncomplying Plans.** A plan with order of benefits determination requirements may coordinate its benefits with a plan that is "excess" or "always secondary" on the following basis:

   - If the complying plan is the primary plan, it shall pay or provide its benefits first.
   - If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In that situation, the payment shall be the limit of the complying plan's liability.
   - If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is required to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

   If the noncomplying plan reduces its benefits so that the Insured Person receives less in benefits than what the Insured would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation, then the complying plan shall advance to or on behalf of the Insured Person an amount equal to the difference.

   The complying plan shall not advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. The complying plan shall:

   - In consideration of the advance, be subrogated to all rights of the Insured Person against the noncomplying company.
   - Be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation in regards to the advance.

   Coordination of benefits differs from subrogation. Provisions for one (1) may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

   If the plans cannot agree on the order of benefits within thirty (30) days after the plans have received all the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary.

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

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

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

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

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

Section 9: Continuation of Coverage

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

Subject to the following terms and conditions, each Insured Person who has been continuously insured under the school's student insurance policy, for at least 3 consecutive months, who no longer meets the Eligibility requirements under the school's student insurance policy, and who loses coverage as a result of a Qualifying Event is eligible to continuation of coverage under the school's student insurance policy then in effect as may be required for student health insurance policies by applicable federal or state law, not to exceed the Maximum Period of Coverage allowed. If the Insured is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase the remainder of the continuation of coverage under the school's student policy in effect.

Qualifying event means any of the following events which result in the loss of coverage of an Insured Person:

- Termination of coverage due to loss of eligibility of the Named Insured.
- In regards to coverage for Dependents, the death of the Named Insured.
- Termination of Dependent coverage due to the Dependent limiting age requirements of the Policy.
- The divorce or legal separation of the Named Insured.

Maximum Period of Continuation of Coverage:

The maximum period of continuation of coverage allowed is a maximum of 18 months after the date of the Qualifying Event.

Notification and Election Requirements:

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

The Insured Person must enroll and pay the required premium within 31 days of the date coverage terminates under this Policy by reason of a Qualifying Event. Coverage becomes effective on the date of the Qualifying Event provided the enrollment and premium payment deadlines are met.

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

Termination of Coverage:

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

- The date this Policy terminates.
- The date the Policyholder no longer provides a student group policy.
- The end of the period through which timely premium payment is made. The payment of any premium will be considered timely if made within 30 days after the date due.
- The date the Insured first becomes eligible for coverage under another group health plan.
- The date the Insured becomes entitled to benefits under Medicare.
- The date required by applicable federal or state law.

Section 10: Definitions

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

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.

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

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

DEPENDENT means the legal spouse 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 mental retardation or physical handicap.
2. Chiefly dependent upon the Insured Person for support and maintenance.

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

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

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

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

EMERGENCY SERVICES means with respect to a Medical Emergency:

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

HABILITATIVE SERVICES means health care services that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy, and other services for people with disabilities.

Habilitative services do not include Elective Surgery or Elective Treatment or services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

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

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

INJURY means bodily injury which is all of the following:

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

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to the Policy's Effective Date will be considered a Sickness under the Policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *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 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.

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

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

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

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

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

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

The Company uses data from FAIR Health, Inc. and/or Data iSight to determine Usual and Customary Charges. Usual and Customary Charges determined using data from FAIR Health, Inc. will be calculated at the 80th percentile. No payment will be made under the Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Section 11: Exclusions and Limitations

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

1. Acne.
2. Acupuncture.
3. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct a congenital anomaly that is present at the time of birth, and that is identified within the first twelve months of birth.
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 Sound, 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.
   This exclusion does not apply to voluntary sterilization.
7. Elective abortion, except to preserve the life of the female upon whom the abortion is performed.
8. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
9. Hirsutism. Alopecia.

10. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
11. Injury sustained while:
    - Participating in any intercollegiate or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
12. Investigational services.
13. Lipectomy.
14. Motor vehicle Injury.
15. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
16. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy for Diabetes Services, Medical Supplies, and Ostomy Supplies.
    - Immunization agents, except as specifically provided in the Policy for Preventive Care Services.
    - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
17. Reproductive services for the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Fertility tests.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
    - 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 for Approved Clinical Trials.
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.
20. Preventive care services, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.

    This exclusion does not apply to benefits specifically provided in the Policy for Preventive Care Services or any screening or testing in the Mandated 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. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
23. Sleep disorders.
24. Supplies, except as specifically provided in the Schedule of Benefits.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy for Reconstructive Surgery following Mastectomy.
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; or while 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. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy for Preventive Care Services or other benefits specifically provided in the Schedule of Benefits.

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

In the event of Injury or Sickness, students should:

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

Submit the above information to the Company by mail:

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

Section 13: General Provisions

GRACE PERIOD: If premium is not paid by the premium due date, the Company shall allow for a thirty (30) day grace period for the payment of any premium due prior to termination of coverage under the Policy.

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

CLAIM FORMS: Claim forms are not required.

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

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid no more than 30 days from the date of due written proof of such loss. If the Company fails to make a good faith attempt to settle a claim within the 30 days, the value of the final settlement shall bear interest at the rate of twelve percent (12%) per annum from and after the expiration of the 30 day period. If the Company fails to settle a claim within the 30 days and the delay was without reasonable foundation, the Insured Person or health care provider shall be entitled to be reimbursed for the reasonable attorney's fees incurred. No part of the fee for representing the claimant in connection with this claim shall be charged against benefits otherwise due to the claimant.

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

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

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

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company. This Subrogation Provision does not apply to 'no-fault' automobile insurance.

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. Except for claims submitted fraudulently, the Company will not seek recovery for reimbursement for overpayment of a claim more than two (2) years from the date the claim was filed.

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 17: 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 30 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. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
7. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Where to Send External Review Requests
All types of External Review requests shall be submitted to the state insurance department Claims Appeals at the following address:

Claims Appeals
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025
1-888-315-0447

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

1. Within 5 business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
3. After receiving notice that a request is eligible for SER, the Commissioner shall, within 1 business day:
   a. Assign an Independent Review Organization (IRO) from the Commissioner's approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
   b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
   c. If the Company reverses it decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 21 calendar days after receipt of all information required from the Company, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. An extension of up to 14 calendar days may be allowed if the Insured Person and the Company agree. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process
An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Company at the time the Insured Person receives:
   a. An Adverse Determination if:

- The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
- The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

b. A Final Adverse Determination, if:
- The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
- The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

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

2. Upon receipt of a request for an EER, the Company shall immediately review the request to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
3. Immediately after completion of the review, the Company shall notify the Commissioner, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an Independent Review Organization (IRO) from the Commissioner's approved list and notify the Company of the name of the assigned IRO.
   a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
   b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
5. a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
   b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
6. In no more than 24 hours after receipt of all information required from the Company, the IRO shall:
   a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
   b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.

An extension of up to 24 hours may be allowed if the Insured Person and the Company agree.

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

Standard Experimental or Investigational Treatment External Review (SEIER) Process

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

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

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Company.

2. Within 5 business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
   b. The recommended or requested health care services or treatment:
      - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
      - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
   c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
      - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      - Standard health care services or treatments are not medically appropriate for the Insured Person;
      - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
   d. The Insured Person's treating Physician:
      - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
      - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
   e. The Insured Person has exhausted the Company's Internal Appeal Process; and
   f. The Insured Person has provided all the information and forms necessary to process the request.
3. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. After receiving notice that a request is eligible for SEIER, the Commissioner shall, within 1 business day:
   a. Assign an IRO from the Commissioner's approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
5. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SEIER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
6. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
   b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
   c. If the Company reverses it decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
8. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or

requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

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

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

   An EEIER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.
2. Upon receipt of an EEIER request notice, the Company shall immediately complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
   b. The recommended or requested health care services or treatment:
      - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
      - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
   c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
      - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      - Standard health care services or treatments are not medically appropriate for the Insured Person;
      - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
   d. The Insured Person's treating Physician:
      - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
      - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
   e. The Insured Person has exhausted the Company's Internal Appeal Process unless the Insured person is not required to do so as specified in sub-sections 1. a. and b. above; and
   f. The Insured Person has provided all the information and forms necessary to process the request.
3. The Company shall immediately notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for an EEIER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. After receiving notice that a request is eligible for EEIER, the Commissioner shall immediately:
   a. Assign an IRO from the Commissioner's approved list; and
   b. Notify the Company of the name of the assigned IRO.

5. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6. a. If the EEIER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EEIER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EEIER.
   b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EEIER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
7. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the EEIER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
8. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
9. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the EEIER.
   b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
   c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
10. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 5 calendar days after being selected by the IRO.
11. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
12. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

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

APPEAL RIGHTS DEFINITIONS

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

Adverse Determination means:

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

Authorized Representative means:

1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or

4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

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

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

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

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

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

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

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

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

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

Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517
800-595-6053 or 502-564-3630
TDD to Voice call 800-648-6056
Voice to TDD call 800-658-6057
http://insurance.ky.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 18: 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/wku

Plan is arranged by:
Academic HealthPlans, Inc.
P. O. Box 1605
Colleyville, TX 76034-1605
wku.myahpcare.com

Customer Service:
1-800-767-0700
(Customer Services Representatives are available Monday - Friday, 7:00 a.m. – 7:00 p.m. (Central Time))

Section 19: Pediatric Dental Services Benefits

Benefits are provided for Covered Dental Services, as described below, for Insured Persons under the age of 21. Benefits terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 21; 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 that is greater than 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 check 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 check the participation status by calling the Company and/or the provider. The Company can help 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 the Insured Person decides to obtain Covered Dental Services 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. 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. When the Insured Person obtains Covered Dental Services from non-Network Dental Providers, the Insured Person must file a claim with the Company to be reimbursed for Allowed Dental Amounts.

What Are 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.

What Is a 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.

Does Pre-Authorization Apply?

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 provided. If the Insured Person does not obtain a pre-authorization, the Company has a right to deny the claim for failure to comply with this requirement.

Section 2: Benefits for Pediatric Dental Services

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

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

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

Network Benefits:

Benefits for Allowed Dental Amounts 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 Allowed Dental Amounts 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 Allowed Dental Amounts.

Dental Services Deductible

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

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

Out-of-Pocket Maximum - any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this section 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

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
Diagnostic Services - (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 D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
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)	50%	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	50%	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	50%	50%
Limited to 1 time per 12 months. D0330 - Panoramic radiograph image	50%	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	50%	50%
Preventive Services - (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	50%	50%
Fluoride Treatments The following services are limited to 2 times every 12 months. D1206 and D1208 - Fluoride	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
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	50%	50%
Space Maintainers (Spacers) The following services are limited to 2 per 12 months. Benefits include all adjustments within 6 months of installation. D1510 - Space maintainer - fixed - unilateral – per quadrant –D1516 - Space maintainer - fixed - bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant	50%	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 D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
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	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 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four surfaces D2740 - Crown - porcelain/ceramic substrate D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
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 services are limited to 1 time per tooth every 60 months. D2929 - Prefabricated porcelain crown - primary 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. D2954 - Prefabricated post and core in addition to crown	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair D2982 - Onlay repair D2983 - Veneer repair D2990 - Resin infiltration/smooth surface	50%	50%
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. 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)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)		
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. D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root	50%	50%
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	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 per quadrant every 12 months.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
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		
The following services are limited to 1 per quadrant every 12 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 bounded teeth spaces per quadrant D4263 - Bone replacement graft - first site in quadrant	50%	50%
The following services are not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure D4271 - Free soft tissue graft procedure	50%	50%
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 12 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation		
The following service is limited to a frequency of 1 per pregnancy. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis	50%	50%
The following service is limited to 2 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
D5282 - Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant		
The following services are limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months. 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 D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5620 - Repair cast framework D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth 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	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
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) 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) D5876 - Add metal substructure to acrylic full denture (per arch)		
The following services are not subject to a frequency limit. D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	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 - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
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 D6530 - Inlay - metallic - three or more surfaces D6543 - Onlay - metallic - three surfaces D6544 - Onlay - metallic - four or more surfaces	50%	50%
The following services are limited to 1 time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer 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	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
D6980 - Fixed partial denture repair necessitated by restorative material failure		
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit. 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 mucoperiosteal flap and removal of bone and/or section of tooth D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal	50%	50%
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	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 D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	50%	50%
The following service is not subject to a frequency limit.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
D7471 - Removal of lateral exostosis (maxilla or mandible)		
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess D7910 - Suture of recent small wounds up to 5 cm D7921 - Collect - apply autologous product D7953 - Bone replacement graft for ridge preservation - per site D7971 - Excision of pericoronal gingiva	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
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	50%	50%
Covered only when clinically Necessary. D9220 - Deep sedation/general anesthesia first 30 minutes D9221 - Dental sedation/general anesthesia each additional 15 minutes D9222 - Deep sedation/general anesthesia - first 15 minutes D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9241 - Intravenous conscious sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9610 - Therapeutic drug injection, by report	50%	50%
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.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch		
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 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 cast predominately base metal crown D6064 - Abutment supported porcelain/ceramic crown D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys 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	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
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 FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys 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 D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant prosthesis D6091 - Replacement of semi-precision or precision attachment D6095 - Repair implant abutment D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Implant removal		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
D6101 - Debridement peri-implant defect D6102 - Debridement and osseous peri-implant defect D6103 - Bone graft peri-implant defect D6104 - Bone graft implant replacement D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 - Implant index D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys		
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, a disabling malocclusion, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, and/or temporomandibular joint (TMJ) conditions. All orthodontic treatment must be prior authorized. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
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	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Non-Network Benefits**
D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular		

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this section to the Policy.

16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO), except as specifically provided under the benefits for Medically Necessary Orthodontics.
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Maxillofacial prosthetic services, except for the following when provided by a board certified prosthodontist:
    - A nasal prosthesis
    - An auricular prosthesis
    - A facial prosthesis
    - A mandibular resection prosthesis
    - A pediatric speech aid
    - An adult speech aid
    - A palatal augmentation prosthesis
    - A palatal lift prosthesis
    - An oral surgical splint
    - An unspecified maxillofacial prosthetic.
25. 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:

Allowed Dental Amounts - Allowed Dental Amounts 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, Allowed Dental Amounts 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, Allowed Dental Amounts are the Usual and Customary Fees, as defined below.

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.

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 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 20: Pediatric Vision Care Services Benefits

Benefits are provided for Vision Care Services, as described below, for Insured Persons under the age of 21. Benefits terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 21; or 2) the date the Insured Person's coverage under the Policy terminates.

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Non-Network Benefits:

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

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

Policy Deductible

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

What Are the Benefit Descriptions?

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 eyes and according to the standards of care in the area where the Insured Person resides, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) – helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation – how well the Insured Person sees up close (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam 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 placed in eyeglass frames and worn on the face to correct visual acuity limitations.

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

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

Eyeglass Frames

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

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

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

Eyeglass Replacement

Replacement of up to one complete pair of eyeglasses per Policy Year if necessary as determined by the Vision Care Provider and subject to the Vision Care Services Schedule of Benefits. Eyeglasses consist of either eyeglass lenses, eyeglass frames, or both eyeglass lenses and frames.

Contact Lenses

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

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

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

Necessary Contact Lenses

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

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

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

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	75% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	75% of the billed charge.
• Bifocal		100% after a Copayment of $40.	75% of the billed charge.
• Trifocal		100% after a Copayment of $40.	75% of the billed charge.
• Lenticular		100% after a Copayment of $40.	75% 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.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%.	75% of the billed charge.
• Eyeglass frames with a retail cost of $130 - $160.		100% after a Copayment of $15.	75% of the billed charge.
• Eyeglass frames with a retail cost of $160 - $200.		100% after a Copayment of $30.	75% of the billed charge.
• Eyeglass frames with a retail cost of $200 - $250.		100% after a Copayment of $50.	75% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of $40.	75% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in Section 1: Benefits for Pediatric Vision Care Services, benefits are not provided under this section 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 Section 1: Benefits for Pediatric Vision Care Services.

Section 21: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

Benefits for Prescription Drug Products

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

Supply Limits

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

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

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy or a Preferred 90 Day Retail 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/wku 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 or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

Designated Pharmacies

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

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/wku 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, benefits will be provided under the out of network 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, benefits will be provided under the out-of-network Prescription Drug benefit 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/wku 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/wku 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.

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

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.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others, therefore; a Prescription Drug may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

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/wku 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 benefit. 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, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources. 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.

Maintenance Medication means a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. The Insured may find out if a Prescription Drug Product is a Maintenance Medication at www.uhcsr.com/wku or by calling *Customer Service* at 1-855-828-7716.

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 90 Day Retail Network Pharmacy means a retail pharmacy that the Company identifies as a preferred pharmacy within the network for Maintenance Medication.

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/wku 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/wku 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/wku or call *Customer Service* at 1-855-828-7716.

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

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

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

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

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

Usual and Customary Fee means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. 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.
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.

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 specifically provided under the Medical Foods benefit in the Medical Expense Benefits section of the Policy.
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

Western Kentucky University
2021-1644-4
METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 79.580%
Injury and Sickness Benefits

Deductible Preferred Provider	$500 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network	$1,000 (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	$6,850 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	$12,000 (For all Insureds in a Family, 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. 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. All Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum.

Graves Gilbert Clinic: Benefits for Covered Medical Expenses provided at Graves Gilbert Clinic at WKU are payable at 100% of Preferred Allowance when the service is rendered by a UnitedHealthcare Choice Plus Preferred Provider. The Policy Deductible and Copays are waived.

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

Inpatient	Preferred Provider	Out-of-Network Provider
Room and Board Expense	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Intensive Care	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Hospital Miscellaneous Expenses	Preferred Allowance after Deductible	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.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Assistant Surgeon Fees	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible

Inpatient	Preferred Provider	Out-of-Network Provider
Anesthetist Services	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Registered Nurse's Services	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Physician's Visits	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Preferred Allowance after Deductible	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.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Day Surgery Miscellaneous	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Assistant Surgeon Fees	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Anesthetist Services	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Physician's Visits	$50 Copay per visit 80% of Preferred Allowance after Deductible	$50 Copay per visit 60% of Usual and Customary Charges after Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$250 Copay per visit 80% of Preferred Allowance after Deductible	$250 Copay per visit 60% of Usual and Customary Charges after Deductible
Diagnostic X-ray Services	$50 Copay per visit 80% of Preferred Allowance after Deductible	$50 Copay per visit 60% of Usual and Customary Charges after Deductible
Radiation Therapy	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Laboratory Procedures	$50 Copay per visit 100% of Preferred Allowance after Deductible	$50 Copay per visit 75% of Usual and Customary Charges after Deductible
Tests & Procedures	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Injections	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible

Outpatient	Preferred Provider	Out-of-Network Provider
Chemotherapy	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit for additional information. The Insured Person is not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications including contraceptives.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $20 Copay per prescription Tier 1 $35 Copay per prescription Tier 2 $60 Copay per prescription Tier 3 up to a 31-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 (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	$20 Copay per prescription generic drug $35 Copay per prescription brand-name drug up to a 31-day supply per prescription not subject to Deductible

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	Preferred Allowance after Deductible	80% of Usual and Customary Charges after Deductible
Durable Medical Equipment	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Consultant Physician Fees	$50 Copay per visit Preferred Allowance after Deductible	$50 Copay per visit Usual and Customary Charges after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Mental Illness Treatment	**Inpatient:** Preferred Allowance after Deductible **Outpatient office visits:** $50 Copay per visit 80% of Preferred Allowance after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Preferred Allowance after Deductible	**Inpatient:** Usual and Customary Charges after Deductible **Outpatient office visits:** $50 Copay per visit 60% of Usual and Customary Charges after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Usual and Customary Charges after Deductible

Other	Preferred Provider	Out-of-Network Provider
Substance Use Disorder Treatment	**Inpatient:** Preferred Allowance after Deductible **Outpatient office visits:** $50 Copay per visit 80% of Preferred Allowance after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Preferred Allowance after Deductible	**Inpatient:** Usual and Customary Charges after Deductible **Outpatient office visits:** $50 Copay per visit 60% of Usual and Customary Charges after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 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
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services, including certain birth control contraceptives and services, are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	75% of Usual and Customary Charges after Deductible
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services	Paid as any other Sickness	Paid as any other Sickness
Home Health Care See Benefits for Home Health Care under the Mandated Benefits section of the Policy.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Hospice Care Hospice Care benefits are not subject to the Policy Deductible.	Paid at least equal to the Medicare benefits for Hospice Care	Paid at least equal to the Medicare benefits for Hospice Care
Inpatient Rehabilitation Facility	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Skilled Nursing Facility	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Urgent Care Center	$50 Copay per visit 100% of Preferred Allowance after Deductible	$50 Copay per visit 75% of Usual and Customary Charges after Deductible
Hospital Outpatient Facility or Clinic	Preferred Allowance after Deductible	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
Hearing Aids	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible

Other	Preferred Provider	Out-of-Network Provider
Medical Foods	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Ostomy Supplies	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Wigs	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Medical Supplies When prescribed by a physician and benefits are limited to a 31-day supply per purchase.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Prosthetic Appliance/Orthotic Device	Preferred Allowance after Deductible	80% of Usual and Customary Charges after Deductible

UNITEDHEALTHCARE INSURANCE COMPANY

UnitedHealthcare Insurance Company P.O. Box 809025 Dallas, TX 75380-9025

POLICY RIDER

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

President

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

BENEFITS FOR ELECTIVE ABORTION

The exclusion will be waived and benefits will be paid for elective abortion as for any other Sickness. Amounts payable for specific services under this benefit are limited by the Schedule of Benefits.

Disclosure of Local Government Premium Taxes Included in Your Policy Premium*

This information is being provided to you currently and will be provided to you annually hereafter with your UnitedHealthcare group health/life insurance policy materials in accordance with a 2008 Kentucky law that requires an insurance company to disclose to policyholders local government taxes included in the insurance premium.

You are receiving this because the disclosure law applies to Kentucky institutions of higher education covered by a fully-insured group health/life contract with UnitedHealthcare Insurance Company. The institution of higher education is considered to be the policyholder.

UnitedHealthcare does include in your group health/life insurance premium the amount of local government premium taxes that it is required to pay to your applicable local government. UnitedHealthcare does not include any local government premium tax collection fee in your premium. For the amount of local government premium taxes included in your annual premium, please refer to the attached Kentucky Local Government Tax Schedule which shows the tax rate for your applicable local government entity(ies).

If you have any questions about this notice, please contact your local UnitedHealthcare representative.

This Disclosure Notice Is Required By Kentucky Law and Is Not Part Of Your Group Policy.

Commonwealth of Kentucky
Local Government Premium Taxes
2021 through 2022 Schedule

Municipality Name	Health	Life
Adairville	None	None
Albany	10%	10%
Alexandria	None	None
Allen	6%	6%
Anchorage	5%	5%
Anderson County	4%	4%
Arlington	8%	8%
Ashland	10%	10%
Auburn	None	None
Audubon Park	9%	9%
Augusta	None	8%
Bancroft	5%	5%
Barbourmeade	None	5%
Barbourville	9%	9%
Bardwell	9%	9%
Barlow	3% or 7%	3% or 7%
Beattyville	4%	8%
Beaver Dam	None	None
Bedford	11%	11%
Beechwood Village	None	5%
Bell County	None	7%
Bellefonte	8%	8%
Bellemeade	None	5%
Bellevue	10%	10%
Bellewood	5%	5%
Benton	7.5%	$18.75 Flat
Berea	None	6%
Berry	7.5%	7.5%
Blue Ridge Manor	5%	5%
Bonnieville	8%	8%
Bowling Green	2%	2%
Bradfordsville	3%	3%
Brandenburg	8%	8%
Breckinridge County	None	5%
Briarwood	5%	5%
Brodhead	6%	6%
Broeck Pointe	5%	5%

Municipality Name	Health	Life
Bromley	None	None
Brooksville	7%	7%
Brownsboro Farm	None	5%
Brownsboro Village	5%	5%
Brownsville	7%	7%
Bullitt County	None	None
Burgin	10%	10%
Burkesville	10%	10%
Burnside	9%	9%
Butler	10%	10%
Cadiz	6%	6%
Calhoun	12%	12%
California	None	10%
Calvert City	7%	7%
Cambridge	5%	5%
Campbell County	None	None
Campbellsburg	12%	12%
Campbellsville	10%	2%
Campton	None	None
Caneyville	None	None
Carlisle	7.5%	7.5%
Carlisle County	4%	4%
Carrollton	8%	8%
Carter County	None	None
Casey County	None	None
Catlettsburg	16%	16%
Cave City	8%	8%
Centertown	None	None
Central City	8%	8%
Clark County	None	None
Clarkson	5%	5%
Clay	None	None
Clay City	None	None
Cloverport	9%	None
Coal Run Village	None	4%
Cold Spring	None	None
Coldstream	5%	5%

Municipality Name	Health	Life
Columbia	10%	10%
Corbin	9%	9%
Corinth	10%	10%
Corydon	12%	12%
Covington*	10%	10%
Crab Orchard	9%	9%
Creekside	5.8%	5.8%
Crescent Springs	5%	10%
Crestview	None	None
Crestwood	10%	10%
Crittenden	9%	9%
Crittenden County	None	None
Crofton	10%	10%
Crossgate	5%	5%
Cumberland	8%	8%
Cynthiana	6%	6%
Danville	None	10%
Daviess County	4.9%	None
Dawson Springs	5%	5%
Dayton	None	None
Dixon	5%	5%
Douglass Hills	None	5%
Dover	7%	7%
Druid Hills	5%	5%
Dry Ridge	8.5%	8.5%
Earlington	10%	10%
Eddyville	None	None
Edmonton	7%	7%
Ekron	3%	10%
Elizabethtown	None	None
Elkhorn City	None	3%
Elkton	None	None
Elliott County	None	None
Elsmere	10%	10%
Eminence	10%	10%
Erlanger	9.75%	9.75%
Evarts	10%	10%

Municipality Name	Health	Life
Ewing	None	6%
Falmouth	10%	10%
Ferguson	6.32%	8%
Fincastle	5%	5%
Flatwoods	None	$25.00
Fleming County	None	6%
Fleming-Neon	5%	5%
Flemingsburg	6%	6%
Florence	5%	5%
Floyd County	4%	4%
Fordsville	8%	8%
Forest Hills	5%	5%
Fort Mitchell	7%	7%
Fort Thomas	10%	10%
Fort Wright	None	8%
Fountain Run	5%	5%
Fox Chase	None	None
Frankfort	6%	6%
Franklin	9%	9%
Franklin County	None	6%
Fredonia	None	None
Frenchburg	5%	5%
Fulton	3%	3%
Fulton County	None	3%
Gamaliel	7%	7%
Georgetown*	8%	8%
Ghent	5%	5%
Glasgow	2%	2%
Glencoe	6%	6%
Glenview	5%	5%
Glenview Hills	None	5%
Glenview Manor	None	None
Goose Creek*	None	5%
Goshen	None	10%
Graymoor-Devondale	None	5%
Grayson	None	None
Green County	None	None
Green Spring	None	5.75%
Greensburg	None	10%
Greenup	None	None
Greenville	11%	11%
Guthrie	None	5%
Hanson	None	10%

Municipality Name	Health	Life
Hardinsburg	6%	None
Harlan	None	8%
Harrodsburg	10%	10%
Hartford	10%	10%
Hawesville	8%	None
Hazard	5%	5%
Hebron Estates	None	None
Henderson	11%	11%
Henderson County	9.75%	9.75%
Heritage Creek	None	5%
Hickman	4%	None
Hickory Hill	None	5%
Highland Heights	None	None
Hills And Dales	None	5%
Hillview	None	None
Hindman	None	3%
Hodgenville	10%	10%
Hollow Creek	5%	5%
Hopkins County	None	10%
Hopkinsville	8.5%	8.5%
Horse Cave	8%	8%
Houston Acres	None	7%
Hunters Hollow	None	None
Hurstbourne	None	8%
Hurstbourne Acres	5%	5%
Hustonville	None	None
Hyden	4%	4%
Indian Hills	5%	5%
Irvine	None	10%
Irvington	10%	10%
Island	11%	11%
Jackson	None	None
Jackson County	None	None
Jamestown	10%	10%
Jeffersontown	None	5%
Jeffersonville	None	4%
Jenkins	6%	6%
Jessamine County	None	9%
Junction City	12%	12%
Kenton County	None	None
Kingsley	5%	None
Knott County	None	None
Kuttawa	None	None

Municipality Name	Health	Life
La Center	None	3%
Lafayette	7%	7%
Lagrange	10%	10%
Lakeside Park	8%	10%
Lancaster	10%	10%
Langdon Place	5%	5%
Lawrenceburg	8%	8%
Lebanon	10%	10%
Lebanon Junction	None	None
Leitchfield	8%	8%
Lewis County	None	6%
Lewisburg	None	None
Lexington-Fayette	5%	5%
Liberty	None	None
Lincolnshire	None	5%
Livermore	10%	10%
Livingston	7%	7%
London	7%	7%
Loretto	3%	3%
Louisa	8%	8%
Louisville Urban Service District	5%	5%
Louisville-Jefferson	None	5%
Loyall	9.2%	9.2%
Ludlow	12%	12%
Lynch	8%	8%
Lyndon	None	5%
Lynnview	None	5%
Madison County*	None	None
Madisonville	None	10%
Manchester	4%	4%
Manor Creek	5%	5%
Marion	4%	4%
Martin	9%	9%
Maryhill Estates	5.75%	5.75%
Mason County	None	7%
Mayfield	9%	9%
Maysville	9%	9%
McCracken Co.*	None	6.9%
McHenry	5%	None
McKee	10%	10%
Meade County	None	5%
Meadowbrook Farm	5%	5%
Meadowview Estates	None	5%

Municipality Name	Health	Life
Melbourne	10%	10%
Menifee County	None	None
Mentor	None	10%
Middlesboro	3%	2%
Middletown	None	5%
Midway	5%	5%
Millersburg	12%	12%
Milton	8%	8%
Mockingbird Valley	5%	5%
Monticello	None	None
Morehead	7.5%	7.5%
Morgan County	None	None
Morganfield	None	None
Morgantown	8%	8%
Mortons Gap	None	10%
Mount Olivet	None	None
Mount Sterling	10%	10%
Mount Vernon	4%	4%
Mount Washington	None	None
Muldraugh	9.5%	9.5%
Munfordville	9.2%	9.2%
Murray	None	None
Murray Hill	None	5%
Nebo	None	10%
New Castle	None	12%
New Haven	None	None
Newport	15%	10%
Nicholas County	None	None
Nicholasville	None	10%
Norbourne Estates	None	5%
North Middletown	9%	9%
Northfield	None	5%
Nortonville	None	10%
Norwood	None	5%
Oak Grove	10%	10%
Oakland	None	None
Oldham County	None	10%
Olive Hill	None	None
Orchard Grass Hills	10%	10%
Owen County	None	None
Owensboro	4%	10%
Owingsville	None	8%

Municipality Name	Health	Life
Owsley County	None	None
Paducah	7%	7%
Paintsville	None	None
Paris	10%	10%
Park City	8%	8%
Park Hills	10%	10%
Parkway Village	5%	5%
Pembroke	5.5%	5.5%
Perryville	None	10%
Pewee Valley	10%	10%
Pineville	8%	8%
Pioneer Village	None	None
Plantation	5%	5%
Pleasureville	10%	10%
Plum Springs	None	None
Powderly	9%	9%
Powell County	None	5%
Prestonsburg	8%	None
Prestonville	6%	6%
Princeton	8%	8%
Prospect	7%	5%
Providence	None	None
Pulaski County	None	5.5%
Raceland*	13%	13%
Radcliff	None	None
Ravenna	10%	10%
Richlawn	None	5%
Richmond	8%	8%
River Bluff	None	10%
Riverwood	None	5%
Robards	8%	8%
Robertson County	None	None
Rockcastle County	None	None
Rockport	6%	6%
Rolling Fields	None	5%
Rolling Hills	5%	5%
Russell Springs	10%	10%
Russellville	None	None
Ryland Heights	7%	7%
Sacramento	8%	8%
Sadieville	10%	10%
Salem*	None	5%

Municipality Name	Health	Life
Salyersville	None	None
Sanders	5%	5%
Sandy Hook	9%	9%
Science Hill	5%	5%
Scottsville	7%	7%
Sebree	7%	7%
Seneca Gardens	5%	5%
Shelbyville	5%	5%
Shepherdsville	None	None
Shively*	1%	12.5%
Silver Grove	None	10%
Simpsonville	5%	5%
Slaughters	5%	5%
Smithfield	None	6.5%
Smithland	None	None
Smiths Grove	5%	7%
Somerset	6%	6%
South Shore	None	None
Southgate	None	None
Sparta	None	6%
Spencer County	None	None
Spring Valley	None	5%
Springfield	6%	6%
Springmill*	None	5%
St. Charles	None	None
St. Matthews	5%	5%
St. Regis Park	None	5%
Stamping Ground	6%	6%
Stanford	9%	9%
Stanton	5%	5%
Strathmoor Manor	7%	7%
Strathmoor Village	5%	5%
Sturgis	12%	12%
Sycamore	None	8%
Taylor Mill	None	8%
Taylorsville	7%	7%
Ten Broeck	None	None
Thornhill	None	5%
Todd County	None	None
Tompkinsville	5%	5%
Trenton	None	6%
Trigg County	None	6%

Municipality Name	Health	Life
Trimble County	None	10%
Uniontown	None	None
Vanceburg	6%	None
Versailles	9%	9%
Vicco	5%	5%
Villa Hills	None	6%
Vine Grove	None	None
Walton	5%	5%
Warsaw	None	None
Washington County	4%	4%
Watterson Park	None	5%
Wayland	8%	8%
Wayne County	None	None
Wellington	5%	5%
West Buechel*	7%	7%
West Liberty	10%	10%
West Point	None	12%
Westwood	6%	6%
Wheatcroft	None	None
Wheelwright	None	5%
White Plains	None	None
Whitesburg	5%	5%
Whitesville	None	None
Wickliffe	None	6.4%
Wilder	None	10%
Wildwood	None	5%
Williamsburg	6%	6%
Williamstown	None	None
Wilmore*	8%	8%
Winchester	10%	10%

Municipality Name	Health	Life
Windy Hills	None	5%
Wingo	None	None
Woodburn	2%	2%
Woodbury	5%	5%
Woodland Hills	None	8%
Woodlawn	None	10%
Woodlawn Park	None	5%
Worthington	8%	8%
Worthington Hills	6%	6%
Worthville	5%	5%
Wurtland	None	None

The asterisk * indicates any municipalities/counties that have adopted a premium tax or amended their taxes, payees or addresses since the last updated edition.

A Louisville Urban Services District has been established, which collects Local Government Premium Taxes on Life/Health Premiums for citizens living within the previous city boundary of Louisville.

Report is sorted by Municipality or County Name.

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
ᏕᏬᏂᎯᏍᏗ ᎤᎾᏓᏍᏕᎸᏗ ᎤᎾᏓᏡᎬᎢ ᏂᎯ ᎡᏣᏪᏐᎢᏍᏓᏗᏍᎢ ᏂᏓᎬᏩᏣᏪᎾ ᎠᏎᏍᎢ. ᏲᏣᏍ ᎠᏂ ᏫᏏᎳᏅᏕ 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 h<u>o</u> 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
ကိာ်တၢ်မၤစၢၤအကိၢ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိဉ်ဟ့ဉ်အပှ့ၤဘဉ်(ခီလီ)နှဉ်လီၤ. 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 ejjeļọk wōņāān. Jouj im kallọk 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، ܡܓܢܐܝܬ، ܐܝܬܠܗ̇ ܩܐ ܝܘܟ݂ܘܢ. ܒܒܥܘܬܐ
ܩܪܘܢ 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
Isẹ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.