UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of

California Institute of the Arts

2023-2024

This Certificate of Coverage is Part of Policy # 2023-756-1

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

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

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

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

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Introduction

Welcome to the UnitedHealthcare Student Resources Student Health Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance 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.

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

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

Section 1: Who Is Covered

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

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

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

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 in compliance with the Policyholder's attendance requirements for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. In the absence of fraud or intentional misrepresentation of material fact, if and whenever the Company discovers that the Policy eligibility requirements have not been met, coverage will be cancelled immediately. Unearned premiums will be refunded.

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

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

Dependent eligibility expires concurrently with that of the Named Insured.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 18, 2023. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 31, 2024. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

The Master Policy provides One Year Term coverage. Coverage renewal is guaranteed for the Named Insured and eligible Dependents, as long as the Policy remains in force and the Named Insured continues to meet the eligibility requirements of the Policy.

Section 3: Extension of Benefits after Termination

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

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

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

Section 4: Pre-Admission Notification

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

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

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

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

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

Section 5: Preferred Provider and Out-of-Network Provider Information

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.

Preferred Providers in the local school area are:

UnitedHealthcare Choice Plus

Preferred Provider Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities.

The easiest way to locate Preferred Providers is through the plan's website at www.uhcsr.com. The website 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 for assistance in finding a Preferred Provider.

The Company arranges for health care providers to take part in the Preferred Provider network. Preferred Providers are independent practitioners. They are not employees of the Company. It is the Insured's responsibility to choose a provider. Our credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

A provider's status may change. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling Customer Service at 1-800-767-0700 and/or by asking the provider when making an appointment for services. A directory of providers is available on the plan's website at www.uhcsr.com.

If an Insured receives a Covered Medical Expense from an Out-of-Network Provider and was informed incorrectly by the Company prior to receipt of the Covered Medical Expense that the provider was a Preferred Provider, either through Our provider directory or in Our response to the Insured's request for such information (via telephone, electronic, web-based or internet-based means), the Insured may be eligible for cost-sharing (Copayment, Coinsurance, and applicable Deductible) that would be no greater than if the service had been provided from a Preferred Provider.

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. An Insured may call the Company at 1-800-767-0700 to find out if they are eligible for continuity of care benefits.

"Preferred Provider Benefits" apply to Covered Medical Expenses that are provided by a Preferred Provider.

"Out-of-Network Provider Benefits" apply to Covered Medical Expenses that are provided by an Out-of-Network Provider.

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

Allowed Amounts are the amounts the Company will pay for Covered Medical Expenses. Refer to the definition of Allowed Amount in this Certificate for information on how the Company determines Allowed Amounts.

Preferred Provider Benefits
The Insured is not responsible for any difference between what the Company pays for Allowed Amounts and the amount the provider bills, except for the Insured Person's cost share obligation as specified in the Schedule of Benefits.

This Certificate includes the following provisions to comply with the applicable requirements of the *Consolidated Appropriations Act (the "Act") (P. L. 116 -260).* These provisions reflect requirements of the Act; however, they do not preempt applicable state law.

Out-of-Network Provider Benefits
Except as described below, the Insured Person is responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the provider bills the Insured and the amount the Company pays for Allowed Amounts.

1. For Ancillary Services received at certain Preferred Provider facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
2. For non-Ancillary Services received at certain Preferred Provider facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied in accordance with applicable law, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
3. For Emergency Services provided by an Out-of-Network Provider, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's applicable Copayment, Coinsurance, or Deductible which is based on the rates that would apply if the service was provided by a Preferred Provider which is based on the Recognized Amount as defined in this Certificate.
4. For Air Ambulance services provided by an Out-of-Network Provider, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's applicable Copayment, Coinsurance, or Deductible which is based on the rates that would apply if the service was provided by a Preferred Provider which is based on the Recognized Amount as defined in this Certificate.

For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social*

Security Act), an ambulatory surgical center (as described in section *1833(i)(1)(A) of the Social Security Act*), and any other facility specified by the Secretary.

Insureds will be responsible for all out of pocket expenses in excess of the Policy limits contained in the Schedule of Benefits.

Surprise Bills

A surprise bill is a bill for Covered Medical Expenses, other than Emergency Services, when an Insured Person receives covered services from a contracting health facility at which, or as a result of which, the Insured receives services provided by an Out-of-Network Physician which are not agreed to in advance in a written agreement between the Out-of-Network Physician and the Insured Person.

When an Insured Person receives a surprise bill, the Insured shall pay no more than the same cost-sharing that the Insured would pay for the same Covered Medical Expenses received from a Preferred Provider.

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

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

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

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

1. If the appointment is scheduled at least 72 hours in advance, the Out-of-Network Provider's notice and consent must be provided to the Insured not later than 72 hours prior to the day when the service will be furnished.
2. If the appointment is scheduled between 72 hours and 24 hours in advance, the Out-of-Network provider's notice and consent must be provided on the day the appointment is scheduled.
3. The written consent is signed at least 24-hours in advance of the care.
4. The consent shall be obtained by the Out-of-Network Physician in a document that is separate from any other document used to obtain the Insured's consent for care.
5. At the time of consent, the Out-of-Network Physician shall provide the Insured with a written estimate of the Insured's total expected Out-of-Pocket cost.
6. The consent shall advise the Insured that care may be obtained from a Preferred Provider at a lower cost.
7. The consent shall be provided in the language spoken by the Insured.
8. The consent shall advise the Insured that any costs incurred as a result of obtaining care from an Out-of-Network provider shall be in addition to Preferred Provider cost-sharing amounts and may not count toward the annual Preferred Provider Out-of-Pocket Maximum or Preferred Provider Deductible.

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

State Continuity of Care

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

This provision shall also apply when:

1. A Preferred Provider Physician's or Preferred Provider facility's contract is terminated due to a change in the terms of participation.
2. The Insured is undergoing a course of institutional care or Inpatient treatment from the Preferred Provider Physician or facility.

Upon the termination of a Preferred Provider Physician's or Preferred Provider facility's contract, the Company will provide timely notice to the Insured regarding their right to elect continuity of care.

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

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

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

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

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

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

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

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

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

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

Section 6: Medical Expense Benefits

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.

Benefits are payable for services delivered via Telemedicine/Telehealth. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section.

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:

ESSENTIAL HEALTH BENEFITS: The following benefits are considered to be Essential Health Benefits.

Inpatient

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Outpatient

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

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

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

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

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

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

16. **Physiotherapy.**
    Includes but is not limited to the following rehabilitative services (including Habilitative Services):
    - Physical therapy.
    - Occupational therapy.
    - Cardiac rehabilitation therapy.
    - Manipulative treatment, unless excluded in the Policy.
    - Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.

    Physiotherapy provided in the Insured Person's home by a home health agency is provided as specified under Home Health Care. Physiotherapy provided in the Insured's home other than by a home health agency is provided as specified under this benefit.

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

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

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

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

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

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

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

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

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

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

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

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

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

Other

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

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

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

If more than one piece of equipment or device can meet the Insured's functional need, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not

durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

See also Benefits for Prosthetic Devices for Speaking Post Laryngectomy.

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

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

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

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

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

29. **Mental Illness Treatment.**
See Benefits for Mental Health and Substance Use Disorders in the Mandated Benefits section of this Certificate.

30. **Substance Use Disorder Treatment.**
See Benefits for Mental Health and Substance Use Disorders in the Mandated Benefits section of this Certificate.

31. **Maternity.**
Same as any other Sickness for the following:
- Inpatient services.
- Outpatient services that are not recommended Preventive Care Services Benefits.
- Maternity services not related to Complications of Pregnancy.

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

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

Benefits include maternity related services not covered under the Preventive Care Services Benefit.

Routine pre-pregnancy, pre-natal, post-partum, and inter-pregnancy office visits (office visits not related to Complications of Pregnancy) and all recommended preventive items and services related to pregnancy shall be provided as described in the Preventive Care Services Benefit provision in this Certificate and shall be payable as referenced in the Preventive Care Services Benefit listed in the Schedule. No cost sharing applies when services are provided by a Preferred Provider.

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 and have been proven to have a beneficial effect on health outcomes. Unless the provision states otherwise, the frequency, method, treatment, or setting for preventive care services are provided as prescribed by the Insured's Physician.

Additional information can be found at: (https://www.healthcare.gov/coverage/preventive-care-benefits/).

The Company will follow the Physician's recommendation for preventive care services that require a determination as to whether an Insured is in a high risk category or part of a high risk population.

Preventive care services include:

- Preventive care services for adults:

    - Abdominal aortic aneurysm one-time screening for men ages 65 to 75 who have smoked at least 100 cigarettes in their lifetime.
    - Alcohol misuse screening and counseling.
    - Anxiety screening for adults.
    - Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.
    - Behavioral counseling to promote a healthy diet and physical activity for adults age 18 and older who are at high risk of cardiovascular disease.
    - Blood pressure screening for adults ages 18 or older without know hypertension.
    - Cholesterol screening for adults of certain ages or at high risk.
    - Colorectal cancer screening for adults 45 to 75.
    - Colonoscopy for a positive result on a test or procedure, other than a colonoscopy, that is a colorectal cancer screening examination or laboratory test.
    - Depression screening for adults.
    - Diabetes (Type 2) and prediabetes screening, and effective preventive interventions for Insureds with prediabetes, for adults 35 to 70 years who are overweight or obese.
    - Diet counseling for adults at high risk for chronic disease.
    - Falls prevention with exercise interventions for adults 65 years and over, living in a community setting.
    - Food and Drug Administration-approved contraceptive drugs, devices, and other products (including those available over the counter) as prescribed by a Physician.
      Includes counseling, initiation of contraceptive use, follow-up care related to contraceptive methods, family planning practices, and sterilization procedures.
      Includes condoms and other contraceptive products approved, cleared, or granted by the FDA, such as mobile apps for contraception based on fertility awareness, if the Insured's Physician deems it is medically appropriate.
    - Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
    - Hepatitis C screening for adults at high risk, and one time for age 18 to 79 without known liver disease, with periodic rescreening for those with continued risk for HCV infection.
    - HIV testing for everyone ages 15 to 65, and other ages at increased risk.
    - Immunization vaccines for adults ages 19 and older according to the CDC's Recommended Adult Immunization Schedule.
    - Lung cancer screening for adults 50 to 80 at high risk for lung cancer who are heavy smokers or who have quit in the past 15 years.
    - Obesity screening and intensive, multi-component behavioral interventions, including but not limited to, counseling sessions.
    - PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV infection through sex or injection drug use.
      Includes testing to initiate PrEP: HIV testing, Hepatitis B and Hepatitic C testing, Creatinine and eCrCL or eGFR testing, pregnancy testing, and STI testing.
      Also includes follow-up and monitoring: HIV testing every 3 months, testing to monitor the effects of the PrEP medication, STI screening and counseling, and adherence counseling.
      PrEp medication includes Truvada (or generic equivalent when available), Descovy and tenofovir disoproxil fumarate (medications available under the plan's prescription drug benefit) as well as Apretude (medication available under the plan's medical benefit). Prior authorization or step therapy will not be imposed on PrEP medications.

- Screening for unhealthy drug use in adults ages 18 and older. Screening includes asking questions about unhealthy drug use, not testing of biological specimens.
- Sexually transmitted infection (STI) prevention counseling for adults at high risk.
- Skin cancer behavioral counseling up to age 24 for adults who are part of a high risk population (such as individuals with ivory or pale skin, light hair and eye color, freckles, or those who sunburn easily).
- Statin preventive medication for adults 40 to 75 at high risk of cardiovascular disease.
- Syphilis screening for all adults who are at increased risk for syphilis infection.
- Tobacco use screening for all adults and cessation interventions for tobacco users, including behavioral interventions, pharmacotherapy, and a combination thereof.
- Tuberculosis screening for certain adults without symptoms at high risk.

- Preventive care services for women:

  - Anemia screening on a routine basis for pregnant women.
  - Anxiety screening for adult women, including those who are pregnant or postpartum, at the recommendation of a Physician.
  - Asymptomatic bacteriuria screening using urine culture in a pregnant person at the recommendation of a Physician.
  - Behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
  - Breast cancer genetic test counseling and risk assessment screening for BRCA- related cancer for women at high risk for breast cancer, including women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or women with an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations. For women with a positive result on the BRCA risk assessment, genetic counseling and, if indicated after counseling, genetic testing.
  - Breast cancer mammography screenings every 1 to 2 years for women age 40 and over.
  - Breast cancer counseling and risk-reducing medications (such as tamoxifen, raloxifene, or aromatase inhibitors) for women age 35 and older at increased risk for breast cancer.
  - Cervical cancer screening.
  - Chlamydia and gonorrhea screening for all pregnant women, sexually active women age 24 and younger and in older women who are at increased risk for infection.
  - Comprehensive lactation support services, including consultation, counseling, education, and breastfeeding equipment and supplies as ordered by the Insured's Physician, to optimize successful initiation and maintenance of breastfeeding for pregnant and nursing women.
  - Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have not been diagnosed with type 2 diabetes before.
  - Domestic and interpersonal violence screening and counseling for all women.
  - Folic acid supplements for women who may become pregnant.
  - Gestational diabetes screening for women 24 weeks or later pregnant and those at high risk of developing gestational diabetes.
  - Hepatitis B screening for pregnant women at their first prenatal visit, at the time of admission to a Hospital or other delivery setting for an Insured with unknown HBsAg status, or with new or continuing risk factors for HBV infection.
  - HIV prevention education and risk assessment in adolescents and women.
  - HIV testing for a pregnant woman upon initiation of prenatal care, at the time of active labor with an undocumented HIV status, and as needed based on risk.
  - Human papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older.
  - Low dose aspirin after 12 weeks gestation for women who are at high risk for preeclampsia.
  - Maternal depression screening for mothers at well-baby visits.
  - Obesity prevention and counseling for midlife women age 40 to 60 years of age with normal or overweight body mass index to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.
  - Osteoporosis screening with bone measurement for women age 65 and older.
  - Osteoporosis screening with bone measurement in postmenopausal women younger than 65 who are at increased risk of osteoporosis.
  - Preeclampsia screening for all pregnant women. Preeclampsia prevention, screening, and preventive medication for all pregnant women who are at high risk for preeclampsia.
  - Perinatal depression counseling interventions for pregnant and postpartum women at increased risk of perinatal depression upon recommendation by the Physician.
  - Rh(D) blood typing and antibody testing for all pregnant women during first visit for pregnancy-related care. Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24-28 weeks gestation, unless

the biological father is known to be Rh(D)-negative. Rh(d) immunoglobulin administration for all unsensitized Rh(D)-negative women during pregnancy and immediately after delivery.
- Sexually transmitted infections screening and counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk for infection.
- Tobacco use screening and behavioral interventions for cessation to pregnant women who use tobacco.
- Urinary incontinence screening.
- Urinary tract or other infection screening for pregnant women.
- Well-woman visits for the delivery and coordination of recommended preventive services.
  Includes pre-pregnancy, prenatal, post-partum, and inter-pregnancy visits, regardless of whether preventive services are provided during the visit.

- Preventive care services for infants, children, and adolescents:

  - Age appropriate physical examination and office visits:
    - One within 3 – 5 days of birth and within 48 to 72 hours after hospital discharge.
    - Once at 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months.
    - Once per year for ages 3 – 21.
  - Alcohol, tobacco, and drug use assessments for adolescents.
  - Anxiety screenings for children and adolescents ages 8 to 18 years, including those who are pregnant or postpartum, at the recommendation of a Physician.
  - Anemia screening at 12 months; risk assessment or screening for newborn, children, or adolescents at the recommendation of a Physician.
  - Autism screening for children at 18 and 24 months.
  - Behavioral/psychosocial assessments and measurements for children at each age based visit through age 21.
  - Bilirubin concentration screening for newborns.
  - Blood pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
  - Blood screening for newborns encompassing screening for all disorders on the Recommended Uniform Screening Panel (RUSP).
  - Cervical dysplasia screening for females.
  - Screening for critical congenital heart disease using pulse oximetry for newborns, after 24 hours of age, before discharge from the Hospital.
  - Depression screening for adolescents.
  - Developmental screening for children under age 3.
  - Developmental surveillance for newborns, children, and adolescents from birth through age 21.
  - Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
  - Fluoride supplements beginning at age 6 months for children and adolescents through age 16 without fluoride in their water source.
  - Fluoride varnish for all infants and children as soon as teeth are present.
  - Food and Drug Administration-approved contraceptive drugs, devices, and other products (including those available over the counter) as prescribed by a Physician.
    Includes counseling, initiation of contraceptive use, follow-up care related to contraceptive methods, family planning practices, and sterilization procedures.
    Includes condoms and other contraceptive products approved, cleared, or granted by the FDA, such as mobile apps for contraception based on fertility awareness, if the Insured's Physician deems it is medically appropriate.
  - Gonorrhea prevention medication for the eyes of all newborns.
  - Hearing screening for all newborns, children, and adolescents:
    - Once for a newborn.
    - Once at ages 4, 6, 8, and 10.
    - Once between age 11 through age 14.
    - Once between age 15 through age 17.
    - Once between age 18 through age 21.
  - Height, weight and body mass index (BMI) measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
  - Hematocrit or hemoglobin screening for children.
  - Hemoglobinopathies or sickle cell screening for newborns.

- Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11 to 17 years of age.
- One HIV screening for all adolescents and additional screenings for adolescents at increased risk.
- Hypothyroidism screening for newborns.
- Immunizations for ages 18 and under pursuant to the CDC's Recommended Child and Adolescent Immunization Schedule, United States, 2021.
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6 month visits.
- Medical history for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Obesity screening for children and adolescents 6 years and older and comprehensive, intensive behavioral interventions to promote improvements in weight status including, but not limited to, counseling.
- Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Preexposure Prophylaxis (PrEP) for HIV-negative adolescents at high risk for getting HIV.
  Includes testing to initial PrEP: HIV testing, Hepatitis B and Hepatitic C testing, Creatinine and eCrCL or eGFR testing, pregnancy testing, and STI testing.
  Also include follow-up and monitoring: HIV testing every 3 months, testing to monitor the effects of the PrEP medication, STI screening and counseling, and adherence counseling.
- Sexually transmitted infection (STI) prevention counseling and screening for sexually active adolescents.
- Skin cancer behavioral counseling for ages 6 months to 24 years for people who are part of a high risk population (such as individuals with ivory or pale skin, light hair and eye color, freckles, or those who sunburn easily).
- Syphilis screening for all adolescents, including asymptomatic, non-pregnant adolescents, who are at increased risk for syphilis infection.
- Tobacco interventions, including education or brief counseling, to prevent the use of tobacco in school-aged children and adolescents who have not started to use tobacco.
- Tuberculin testing for children at high risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Vision screening for all children and adolescents through age 21.
- Well-baby and well-child visits.

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

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

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

36. **Home Health Care.**
Services provided in the home by a Registered Nurse, medical social worker, home health aide, and physical, occupational, and speech therapists that are all of the following:
- Ordered by a Physician.
- The Insured Person is substantially confined to their own home (or a friend's or relative's home).
- The Insured Person's condition requires the services of a Registered Nurse, physical therapist, occupational therapist, or speech therapist. (Home health aide services are not covered unless the Insured is also receiving services from a Registered Nurse, physical therapist, occupational therapist, or speech therapist.)
- Pursuant to a home health plan.

Home Health Care services do not include:
- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training.
- Care in the home if the home is not a safe and effective treatment setting.

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

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

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

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

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

40. **Urgent Care Center.**
Benefits are limited to:
- 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:
- 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 and is described in any of the following:

- 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 if the study or investigation has been reviewed and approved through a system of peer review. The peer review system 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 Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

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

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

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

45. **Abortion and Abortion Related Services.**
Benefits are payable for all abortion and abortion related services, including pre-abortion and follow-up services.

Benefits include:

- Office visits and Physician services for examinations, prescriptions, and referrals.
- Outpatient facility fees.
- Telehealth.
- Anesthesia.
- Inpatient Facility fees and related Physician fees.

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

47. **Bariatric Surgery.**
Benefits are payable for bariatric surgical procedures when a Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary.

Benefits include:
- Inpatient surgery performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption.
- Room and board expenses.
- Hospital miscellaneous expenses.

Benefits also include certain travel and lodging expenses when the Insured must travel 50 miles or more to the facility where the bariatric surgical procedure is performed. Authorized and documented travel and lodging expenses will be reimbursed as follows:
- The Insured's transportation to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit).
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit).
- One hotel room, double-occupancy, for the Insured and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip.
- Hotel accommodations for one companion not to exceed $100 per day for the duration of the Insured's surgery stay, up to four days.

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

See also Benefits for Phenylketonuria.

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

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

50. **Vision Correction.**
Benefits are payable for the following when not covered under the Pediatric Vision Care Services benefit:
- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) per Policy Year to treat aniridia.
- Up to six Medically Necessary contact lenses per eye (including fitting and dispensing) per Policy Year to treat aphakia for Insureds through age nine.

Section 7: Mandated Benefits

In addition to the Essential Health Benefits described in the Medical Expense Benefits section, the following Mandated Benefits are required, and therefore considered to be essential, by California law:

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid for screening and diagnostic mammography performed to detect the presence of occult breast cancer, upon the referral of a nurse practitioner, certified nurse midwife, physician assistant, or Physician.

Mammograms covered by the Preventive Care Services Benefit shall be provided as described in the Preventive Care Services Benefit provision in this Certificate. Benefits shall be payable as referenced in the Preventive Care Services Benefit listed in the Schedule. No cost sharing applies when services are provided by a Preferred Provider.

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

BENEFITS FOR UPPER OR LOWER JAWBONE SURGERY

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

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

BENEFITS FOR RECONSTRUCTIVE SURGERY

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

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

See Benefits for Mental Health and Substance Use Disorders for reconstructive surgery related to gender dysphoria.

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

BENEFITS FOR PROSTHETIC DEVICES FOR SPEAKING POST LARYNGECTOMY

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

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

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

BENEFITS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Benefits will be provided for the diagnosis and Medically Necessary Treatment of a Mental Health or Substance Use Disorders, including all basic health care services, and prescription drugs, in accordance with the Federal Mental Health Parity and Addiction Equity Act.

Benefits include:

1. Basic health care services.
    - Physician services.
    - Inpatient hospital services.
    - Outpatient services (including physical therapy, occupational therapy, speech therapy).
    - Diagnostic laboratory services.

- Diagnostic and therapeutic radiologic services.
- Home health services.
- Emergency services.
- Ambulance transportation and out-of-area coverage (emergency and urgent care while outside the service area).
- Preventive Care Services.
- Hospice care.
- Fertility preservation for iatrogenic infertility.

2. Intermediate services.
   Full range of levels of care, including but not limited to:
   - Residential treatment.
   - Partial hospitalization.
   - Intensive outpatient treatment.
3. Mental health benefits.
   - Mental health counseling.
   - Psychological and neuropsychological testing.
   - Electroconvulsive treatment.
   - Transcranial magnetic stimulation.
   - Sleep study/polysomnography (sleep-wake disorders).
   - Esketamine (drug for certain types of depression administered in certified health care setting).
4. Substance use disorder benefits.
   - Inpatient, residential, and outpatient withdrawal management (drug detoxification) and treatment/rehabilitation.
   - Medication management, including office-based opioid treatment (medication-assisted treatment with buprenorphine).
   - Narcotic treatment programs, including MAT with methadone.
   - Certified addiction counselor services.
5. Gender dysphoria benefits.
   - Mental health professional services.
   - Feminizing/masculinizing hormone therapy.
   - Puberty suppressing hormones (adolescents).
   - Surgery and reconstructive surgery to change primary and/or secondary characteristics (breast, genital, gonadectomy, facial features, hair removal, etc.). For the purposes of treatment for gender dysphoria, reconstructive surgery means Medically Necessary surgery to create a normal appearance for the gender with which the Insured identifies.
   - Voice surgery.
   - Speech therapy.
   - Fertility preservation.

"Mental health or substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD-10), or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of these two references shall not affect the conditions covered by this mandate as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

"Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of the Insured Person, for the purpose of preventing, diagnosing, or treating a Sickness, Injury, condition, or its symptoms, including minimizing the progression of a Sickness, Injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the Generally Accepted Standards of Mental Health or Substance Use Disorder Care.
2. Clinically appropriate in terms of type, frequency, extent, site, and duration.
3. Not primarily for the economic benefit of the Company or Insured Person or for the convenience of the Insured Person, treating Physician, or other Health Care Provider.

"Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties, such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed

scientific studies and medical literature, clinical practice guidelines, and recommendations of nonprofit health care provider professional associations, specialty societies, and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

For the purpose of this benefit, "Health Care Provider" means any of the following providers:

- A person who is licensed under Division 2 (commencing with Section 500) of the California Business and Professions Code.
- An associate marriage and family therapist or marriage and family therapist trainee.
- A qualified autism service provider or qualified autism service professional certified by a national entity.
- An associate clinical social worker.
- An associate professional clinical counselor or professional clinical counselor trainee.
- A registered psychologist.
- A registered psychological assistant.
- A psychology trainee.

If the Medically Necessary Treatment of a Mental Health or Substance Use Disorder is not available from a Preferred Provider within the Preferred Provider network geographic and timely access standards set by law or regulation, the Company shall arrange for the delivery of the Medically Necessary Out-of-Network services and follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. Covered Medical Expenses for the Out-of-Network services will be covered at the Preferred Provider level of benefits.

Benefits will also be provided at the Preferred Provider benefit level for Behavioral Health Crisis Services provided to an Insured by a 988 center or mobile crisis team, regardless of whether the service is provided by an Preferred Provider or Out-of-Network Provider.

"Behavioral Health Crisis Services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a Mental Health or Substance Use Disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

Benefits will also be provided for the diagnosis and Medically Necessary Behavioral Health Treatment for Pervasive Developmental Disorder or Autism.

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

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

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

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

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

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

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

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

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

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

All Utilization Review of covered Mental Health and Substance Use Disorder services must be made using the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty or, if outside the scope of any such criteria and guidelines, on current generally accepted standards of Mental Health and Substance Use Disorder care.

Refer to the Mental Health Benefits and Substance Use Disorder line items in the Schedule of Benefits.

- Services for Mental Health or Substance Use Disorder that are delivered while admitted to a facility or program with a residential component (e.g., Hospital admission, Inpatient physician visits, Inpatient withdrawal management, Inpatient surgery, residential treatment, room and board expenses, etc.) shall be paid as indicated under Inpatient in those line items.
- Outpatient services for Mental Health or Substance Use Disorder that are delivered in the office setting and performed for a routine office-visit type service (e.g., Outpatient Physician visits, counseling, medication management including office-based opioid treatment, injections, etc.) shall be paid as indicated under Outpatient office visits in those line items.
- Other outpatient services for Mental Health or Substance Use Disorder (e.g., partial hospitalization/day treatment, intensive outpatient treatment, psychological and neuropsychological testing, outpatient withdrawal management, outpatient surgery and therapy for gender dysphoria, etc.) shall be paid as indicated under All other outpatient services, except Medical Emergency Expenses and Prescription Drugs, in those line items.

Benefits shall be paid as specified in the Policy Schedule of Benefits and shall be subject to the same terms and conditions as applicable to other Sickness and in accordance with the federal Mental Health Parity and Addiction Equity Act.

BENEFITS FOR CARE EVALUATION AND RELATED HEALTH CARE SERVICES

Benefits will be paid the same as any other Sickness for a clinical evaluation performed by a licensed behavioral health professional and any related health care services provided pursuant to a CARE Agreement or CARE Plan.

“CARE agreement" means a voluntary settlement agreement entered into by the parties. A CARE agreement includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports.

"CARE plan" means an individualized, appropriate range of community-based services and supports, as set forth in this part, which include clinically appropriate behavioral health care and stabilization medications, housing, and other supportive services, as appropriate.

No cost sharing applies to services described in this benefit, excluding Prescription Drugs.

BENEFITS FOR DIABETES

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

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

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

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

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

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

BENEFITS FOR PHENYLKETONURIA

Benefits will be paid for the Allowed Amount for the testing and treatment of Phenylketonuria (PKU).

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

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

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

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

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

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

BENEFITS FOR OSTEOPOROSIS

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

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

BENEFITS FOR BREAST CANCER SCREENING AND TREATMENT

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

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

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

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

Breast cancer screenings covered by the Preventive Care Services Benefit shall be provided as described in the Preventive Care Services Benefit provision in this Certificate. Benefits shall be payable as referenced in the Preventive Care Services Benefit listed in the Schedule. No cost sharing applies when services are provided by a Preferred Provider.

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

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

BENEFITS FOR AIDS VACCINE

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

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

BENEFITS FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTS

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

HIV testing covered by the Preventive Care Services Benefit shall be provided as described in the Preventive Care Services Benefit provision in this Certificate. Benefits shall be payable as referenced in the Preventive Care Services Benefit listed in the Schedule. No cost sharing applies when services are provided by a Preferred Provider.

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for screening and diagnosis of prostate cancer, including, but not limited to prostate-specific antigen testing (PSA) and digital rectal examinations when Medically Necessary and consistent with good professional practice.

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

BENEFITS FOR CANCER SCREENING TESTS

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

Cancer screenings covered by the Preventive Care Services Benefit shall be provided as described in the Preventive Care Services Benefit provision in this Certificate. Benefits shall be payable as referenced in the Preventive Care Services Benefit listed in the Schedule. No cost sharing applies when services are provided by a Preferred Provider.

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

BENEFITS FOR CERVICAL CANCER SCREENING

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

An annual screening test will include:

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

Cervical cancer screenings covered by the Preventive Care Services Benefit shall be provided as described in the Preventive Care Services Benefit provision in this Certificate. Benefits shall be payable as referenced in the Preventive Care Services Benefit listed in the Schedule. No cost sharing applies when services are provided by a Preferred Provider.

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

BENEFITS FOR OUTPATIENT CONTRACEPTIVE DRUGS, DEVICES, AND CONTRACEPTIVE METHODS FOR WOMEN

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

- Approved by the Federal Food and Drug Administration.
- Prescribed by the Insured's Physician.

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

Outpatient contraceptive drugs, devices, and contraceptive methods for women covered by the Preventive Care Services Benefit shall be provided as described in the Preventive Care Services Benefit provision in this Certificate. Benefits shall be payable as referenced in the Preventive Care Services Benefit listed in the Schedule. No cost sharing applies when services are provided by a Preferred Provider.

BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

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

The total Copayment and Coinsurance an Insured Person is required to pay shall not exceed $250 for an individual prescription of up to a 31-day supply per prescription.
Benefits shall be subject to all Deductible, limitations, and any other provision of the Policy.

BENEFITS FOR HOME TEST KITS FOR SEXUALLY TRANSMITTED DISEASES

Benefits will be provided for home test kits for sexually transmitted diseases (STDs), including any laboratory costs for processing the kit, that are Medically Necessary or appropriate and ordered directly by a Preferred Provider, or furnished through a standing order for an Insured's use based on clinical guidelines and the Insured's health needs.

"Home test kit" means a product used for a test recommended by the federal *Centers for Disease Control and Prevention* guidelines or the *United States Preventive Services Task Force* that has been waived under the federal *Clinical Laboratory Improvement Act* (*CLIA*), *FDA*-cleared or approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow Insureds to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

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

BENEFITS FOR SERVICES DURING A PUBLIC HEALTH EMERGENCY

Benefits will be provided for the services listed below to prevent or mitigate a disease when the Governor of California has declared a public health emergency due to that disease.

- Evidence-based item, service, or immunization that is intended to prevent or mitigate a disease as recommended by the United States Preventive Services Task Force that has in effect a rating of "A" or "B" or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.
- A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the Federal Centers for Disease Control and Prevention.
- Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.

These items will be covered no later than 15 business days after the date the recommendation is made.

No cost sharing applies when the services listed above are provided during a declared public health emergency for the disease to which the emergency applies.

BENEFITS FOR COVID-19 TESTING, SERVICES, AND IMMUNIZATIONS

Benefits will be provided for COVID-19 diagnostic and screening testing and health care services related to Diagnostic Testing and Screening Testing approved or granted emergency use authorization by the federal Food and Drug Administration.

"Diagnostic testing" means all of the following:

- Testing intended to identify current or past infection and performed when an Insured has signs or symptoms consistent with COVID-19, or when an Insured is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.
- Testing an Insured with symptoms consistent with COVID-19.
- Testing an Insured as a result of contact tracing efforts.
- Testing an Insured who indicates they were exposed to someone with a confirmed or suspected case of COVID-19.
- Testing an Insured after an individualized clinical assessment by a licensed health care provider.

"Screening testing" means tests that are intended to identify people with COVID-19 who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening testing helps to identify unknown cases so that measures can be taken to prevent further transmission. Screening testing includes testing of all the following:

- Workers in a workplace setting.
- Students, faculty, and staff in a school setting.
- A person before or after travel.
- At home testing for a person who does not have symptoms associated with COVID-19 and who does not have known exposure to a person with COVID-19.

Services related to Diagnostic Testing and Screening Testing include, but are not limited to, hospital or health care provider office visits for the purpose or receiving testing, products related to testing, the administration of testing, and items and services furnished to an Insured as part of testing.

Benefits include items, services, immunizations, or therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration that are intended to prevent or mitigate COVID-19 and the items or services necessary for the furnishing of an item, service, or immunization including, but not limited to, office visits, and vaccine administration, whether provided by a Preferred Provider or an Out-of-Network Provider.

Prior authorization or other utilization management requirements do not apply to this benefit.

No cost sharing applies to services described in this benefit when provided during the federal public health emergency.

Six months after the expiration of the COVID-19 federal public health emergency, when services are provided by an Out-of-Network Provider, benefits shall be subject to the Out-of-Network Provider Deductible, Copayment, and Coinsurance.

Section 8: Coordination of Benefits Provision

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

Definitions

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

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

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

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

   Plan does not include any of the following:
   - Hospital indemnity coverage benefits or other fixed indemnity coverage.
   - Accident only coverage.
   - Limited benefit health coverage as defined by state law.
   - Specified disease or specified accident coverage.
   - School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
   - Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
   - Medicare supplement policies.
   - State Plans under Medicaid.
   - A governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other nongovernmental Plan.
   - An Individual Health Insurance Contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:
   - First, the Plan of the parent with custody of the child.
   - Then the Plan of the spouse of the parent with the custody of the child.
   - The Plan of the parent not having custody of the child.
   - Finally, the Plan of the spouse of the parent not having custody of the child.

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

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

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

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

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

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

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

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

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

Section 9: Definitions

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

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

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional

premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

AIR AMBULANCE means medical transport by rotary wing air ambulance or fixed wing air ambulance as defined in *42 CFR 414.605*.

ALLOWED AMOUNT means the maximum amount the Company is obligated to pay for Covered Medical Expenses. Allowed amounts are determined by the Company or determined as required by law, as described below.

Allowed amounts are based on the following:

When Covered Medical Expenses are received from a Preferred Provider, allowed amounts are the Company's contracted fee(s) with that provider.

When Covered Medical Expenses are received from an Out-of-Network Provider as described below, allowed amounts are determined as follows:

1. **For non-Medical Emergency Covered Medical Expenses received at certain Preferred Provider facilities from Out-of-Network Provider Physicians** when such services are either: a) Ancillary Services; or b) non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary, the allowed amount is based on one of the following in the order listed below as applicable:
   - The reimbursement rate as determined by state law.
   - The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
   - The amount determined by *Independent Dispute Resolution (IDR)*.

   For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center (as described in section *1833(i)(1)(A) of the Social Security Act*), and any other facility specified by the Secretary.

2. **For Emergency Services provided by an Out-of-Network Provider**, the allowed amount is based on one of the following in the order listed below as applicable:
   - The reimbursement rate as determined by state law.
   - The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
   - The amount determined by *Independent Dispute Resolution (IDR)*.

3. **For Air Ambulance transportation provided by an Out-of-Network Provider**, the allowed amount is based on one of the following in the order listed below as applicable:
   - The reimbursement rate as determined by state law.
   - The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
   - The amount determined by *Independent Dispute Resolution (IDR)*.

When Covered Medical Expenses are received from an Out-of-Network Provider, except as described above, allowed amounts are determined based on either of the following:

1. Negotiated rates agreed to by the Out-of-Network Provider and either the Company or one of Our vendors, affiliates or subcontractors.
2. If rates have not been negotiated, then one of the following amounts:
   - Allowed amounts are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographical market, with the exception of the following.
     - 50% of CMS for the same or similar freestanding laboratory service.
     - 45% of CMS for the same or similar Durable Medical Equipment from a freestanding supplier, or CMS competitive bid rates.
     - 70% of CMS for the same or similar physical therapy service from a freestanding provider.
   - When a rate for all other services is not published by CMS for the service, the allowed amount is based on 20% of the provider's billed charge.

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically put in place within 30 to 90 days after CMS updates its data.

ANCILLARY SERVICES means items and services provided by Out-of-Network Provider Physicians at a Preferred Provider facility that are any of the following:

1. Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
2. Provided by assistant surgeons, hospitalists, and intensivists.
3. Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary.
4. Provided by such other specialist practitioners as determined by the Secretary.
5. Provided by an Out-of-Network Provider Physician when no other Preferred Provider Physician is available.

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; and 3) the diagnosis of which is distinct from pregnancy.

This definition does not include a condition simply associated with the management of a difficult 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 health care services and supplies which are all of the following:

1. Provided for the purpose of preventing, evaluating, diagnosing, treating, or minimizing the progression of a Sickness or Injury, or its symptoms.
2. Medically Necessary.
3. Not in excess of the Allowed Amount or the Recognized Amount when applicable.
4. Not in excess of the maximum benefit payable per service as specified in the Schedule of Benefits.
5. Not excluded in this Certificate under the Exclusions and Limitations.
6. 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.

Covered Medical Expenses also include Urgent Care Services as defined in this Certificate.

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

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

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

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

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

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

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

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

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

EMERGENCY SERVICES means with respect to a Medical Emergency:

1. An appropriate medical screening, examination, and evaluation that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition.
2. Such further medical examination and treatment to relieve or eliminate the emergency medical condition (including active labor) or to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)*).
3. Ambulance and ambulance transport services.

Emergency services include items and services otherwise covered under the Policy when provided by an Out-of-Network Provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient stay or outpatient stay that is connected to the original emergency medical condition, unless each of the following conditions are met:

1. The attending Physician or treating provider for the Medical Emergency determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available Preferred Provider or Preferred Provider facility located within a reasonable distance taking into consideration the patient's medical condition.
2. The provider furnishing the additional items and services satisfied the notice and consent criteria in accordance with applicable law.
3. The patient is in such a condition to receive information as stated in 2 above and to provide informed consent in accordance with applicable law.
4. The provider or facility satisfied any additional requirements or prohibitions as may be imposed by state law.

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

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour

nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT means a health care facility that: 1) is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and 2) provides Emergency Services.

INJURY means bodily injury which is all of the following:

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

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

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

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

INPATIENT REHABILITATION FACILITY means a long term 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 a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect would result in any of the following:

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

Medical Emergency includes Active Labor. Active Labor means a labor at a time at which either of the following would occur:

1. There is inadequate time to make a safe transfer to another hospital prior to delivery.

2. A transfer may pose a threat to the health and safety of the Insured or the unborn child.

Medical Emergency also includes a psychiatric emergency medical condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Insured as being either of the following:

1. An immediate danger to himself or herself or others.
2. Immediately unable to provide for or utilize, food, shelter, or clothing due to a mental disorder.

Expenses incurred for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

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

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

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

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

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

See Benefits for Mental Health and Substance Use Disorders for the definition of Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

MENTAL ILLNESS means a Sickness that is a Mental Health or Substance Use Disorder as defined in Benefits for Mental Health and Substance Use Disorders.

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-NETWORK PROVIDER means a provider who does not have a contract with the Company to provide services to Insured Persons.

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 12-month 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.

PREFERRED PROVIDER means a provider that has a participation agreement in effect (either directly or indirectly) with the Company or Our affiliates to participate in Our preferred provider network. Our affiliates are those entities affiliated with the Company through common ownership or control with Us or with Our ultimate corporate parent, including direct and indirect subsidiaries.

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.

RECOGNIZED AMOUNT means the amount which any Copayment, Coinsurance, and applicable Deductible is based on for the below Covered Medical Expenses when provided by Out-of-Network Providers:

1. Out-of-Network Emergency Services.
2. Non-Emergency Services received at certain Preferred Provider facilities by Out-of-Network Provider Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in order listed below as applicable:

1. Applicable state law.
2. The qualifying payment amount as determined under applicable law.

The recognized amount for Air Ambulance services provided by an Out-of-Network Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Medical Expenses that use the recognized amount to determine the Insured's cost sharing may be higher or lower than if cost sharing for these Covered Medical Expenses were determined based on an Allowed Amount.

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

SECRETARY means the term secretary as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

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

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

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

SUBSTANCE USE DISORDER means a Sickness that is a Mental Health or Substance Use Disorder as defined in Benefits for Mental Health and Substance Use Disorders.

TELEHEALTH/TELEMEDICINE means the mode of delivering health care services and public health via live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of an Insured's health care while the Insured is at the originating site and the Physician is at a distant site. The site may be a CMS defined originating facility or another location such as an Insured Person's home or place of work.

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.

URGENT CARE SERVICES means those health care services for the treatment of conditions that require prompt medical attention but that are not a Medical Emergency. Urgent Care Services include treatment for an unforeseen Sickness, unforeseen Injury, or unforeseen complication of an existing condition, including pregnancy, which is necessary to prevent serious deterioration of the Insured's health or the health of the Insured's unborn child.

Section 10: Exclusions and Limitations

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

1. Addictive, mental, and behavioral conditions and problems that may be the focus of clinical attention but are specifically noted not to be a mental disorder within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or the Mental and Behavioral Disorders chapter of the ICD-10.
2. Cosmetic procedures performed to alter or reshape normal structures of the body in order to improve the Insured's appearance.
   This exclusion does not apply to:
   - Benefits for Reconstructive Surgery and Benefits for Upper or Lower Jawbone Surgery in the Mandated Benefits section of the Policy.
   - Medically Necessary treatment of gender dysphoria.
   - Reconstructive Breast Surgery Following Mastectomy.
   - Reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy.

   Examples of cosmetic procedures include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male or female breast or nipple.
   - Removal of excess skin.
   - Circumcision for religious reasons or aesthetic purposes.
   - Hair removal.
   - Hair loss or growth treatment, items, and services for the promotion, prevention, or other treatment of hair loss or hair growth.
   - Nasal and sinus surgery performed for any reason other than for the treatment of an Injury or Sickness.
3. Custodial Care. This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Home Health Care, Hospice Care, Inpatient Rehabilitation Facility care, or Skilled Nursing Facility care.
4. Dental treatment, except:
   - For accidental Injury to Natural Teeth.
   - As described under Dental Treatment in the Medical Expense Benefits section of the Policy.

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

   This exclusion does not apply to preventive due to conditions associated with metabolic, neurolgic, or peripheral vascular disease.

7. Health spa or similar facilities. Strengthening programs.
8. Hearing aids. Treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which is not part of a disease process and does or can impair normal hearing.
   This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of an infection or Injury.
   - A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
   - Benefits for Reconstructive Surgery in the Mandated Benefits section of the Policy.
9. Injury or Sickness for which benefits are paid:
   - Under any Workers' Compensation or occupational Disease Law or Act, or similar legislation.
10. Commission of or attempt to commit a felony.
11. Prescription Drugs Services – no benefits will be payable for:
   - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs. The Insured may request an Independent Medical Review (IMR) from the California Department of Insurance (CDI) at no cost to the Insured as described in the Notice of Appeal Rights section of the Policy.
   - Products used solely for cosmetic purposes.
   - Drugs used to treat hair loss or hair growth. Anabolic steroids used for body building.
   - Fertility agents.
   - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
12. Reproductive services for the following:
   - Genetic counseling and genetic testing, except for the prenatal diagnosis of fetal genetic disorders.
   - Cryopreservation of reproductive materials. Storage of reproductive materials. This exclusion does not apply when an Insured received covered treatment that may directly or indirectly cause iatrogenic infertility.
   - Fertility tests.
   - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
   - Reversal of sterilization procedures.
13. 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.
14. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
   This exclusion does not apply as follows:
   - When due to a covered Injury or disease process.
   - To benefits specifically provided in Pediatric Vision Services.
   - To benefits specifically provided in the Policy Schedule of Benefits.
   - To eye examinations, including preventive screenings, for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.
15. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Medical Expense Benefits section of Policy. This exclusion does not apply to the Preventive Care Services benefits outlined in the Medical Expense Benefits section of the Policy.
16. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
17. Naturopathic services.
18. Medical supplies (prescribed or non-prescribed) and disposable supplies. (Examples include gauze and dressings, compression stockings, ace bandages).
   This exclusion does not apply to:
   - Ostomy and Urological Supplies in the Medical Expense Benefits section of the Policy.
   - Benefits for Diabetes in the Mandated Benefits section of Policy.
19. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices. This exclusions does not apply to:
   - Reconstructive Breast Surgery Following Mastectomy in the Medical Expense Benefits section of the Policy.
   - Benefits for Breast Cancer Screening and Treatment in the Mandated Benefits section of the Policy.
   - Benefits for Reconstructive Surgery in the Mandated Benefits section of the Policy.
   - Medically Necessary reconstructive procedures that are for the treatment of gender dysphoria.
20. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
21. War or any act of war, declared or undeclared; while serving in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

22. Weight loss and nutrition programs (for example: Weight Watchers®, Jenny Craig®, or other structured commercial weight loss programs) whether or not they are under medical supervision. This exclusion does not apply to benefits specifically provided in the Preventive Care Services benefit in the Medical Expense Benefits section of the Policy.

Section 11: How to File a Claim for Benefits

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

If submitting a claim by mail, send the above information to the Company at:

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

Section 12: General Provisions

GRACE PERIOD: A grace period of 31 days will be provided for the payment of each premium payment due after the first premium. The Insured Person's premium must be received during the grace period to avoid a lapse in coverage, and the Insured Person must meet the eligibility requirements each time a premium payment is made.

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

CLAIM FORMS: Claim forms are not required.

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

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

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, be paid directly to the Hospital or person rendering such service, unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss.

Indemnities provided under the Policy for any of the Out-of-Network Provider services listed in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* will be paid directly to the Provider.

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

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

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

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

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

REQUEST FOR ALTERNATE COMMUNCATIONS: A protected individual, who is an Insured Person covered by this Policy, may submit a written request to the Company to direct communications regarding a sensitive service to an alternate mailing address, email address, or telephone number. To obtain an alternate communications request form, the protected individual should contact the Company at 1-800-767-0700 or obtain the request form on the Company's website at www.uhcsr.com.

A "protected individual" is any covered adult or covered minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law.

"Sensitive services" are services related to mental or behavioral health, sexual or reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, or intimate partner violence.

Section 13: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

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

The written Internal Appeal request should include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expedited Internal Review

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

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

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

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

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

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

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

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

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

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

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

RIGHT TO EXTERNAL INDEPENDENT MEDICAL REVIEW

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

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

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

The External Independent Medical Review Process

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

the Insured receives the Final Adverse Benefit Determination notice. However, the Commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

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

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

1. a. A copy of all of the Insured's medical records in the possession of the insurer relevant to each of the following:
   (i) The Insured's medical condition.
   (ii) The health care services being provided by the Physician for the condition.
   (iii) The disputed health care services requested by the Insured for the condition.
   b. Any relevant medical records kept by the Company or Physician and discovered or developed after the initial documents were provided to the Independent Medical Review Organization shall be forwarded immediately to the Independent Medical Review Organization. The Company shall concurrently offer to send copies of this documentation to the Insured or, with the Insured's permission, to the Insured's Physician, unless the Insured declines such an offer or the offer is prohibited by law. The documents shall remain confidential as required by state and federal law.
   c. Copies of all information the Company or Physician provided to the Insured regarding the Company's or Physician's decisions regarding the Insured's care or condition, including the Company's written response to the Insured's Internal Appeal.
   d. Copies of all information the Insured or the Insured's Physician provided to the Company in support of the Insured's request for the disputed health care services.
   e. Any other relevant documents or information used by the Company in determining whether disputed health care services should have been provided. The Company shall concurrently send copies of this documentation to the Insured and the Insured's Physician unless the Commissioner finds the material to be legally privileged. The Department and the Independent Medical Review Organization shall maintain the confidentiality of all documents found by the Commissioner to be proprietary information.
   f. Any statements by the Company explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of Medical Necessity or not being a Covered Medical Expense benefit under the Policy. The Company shall concurrently send copies of this documentation to the Insured and the Insured's Physician unless the Commissioner finds the material to be legally privileged. The Department and the Independent Medical Review Organization shall maintain the confidentiality of all documents found by the Commissioner to be proprietary information.
2. Upon submitting all the necessary documents to the Independent Medical Review Organization, the Company shall:
   a. Provide the Insured with an annotated list of all documents submitted.
   b. Offer to provide copies to the documents, upon request from the Insured.
3. The Independent Medical Review Organization's reviewer must decide the matter within 30 days of receiving the application and supporting documents. The Department may extend this by 3 days in extraordinary circumstances or for good cause.
4. The Independent Medical Review Organization must provide its reviewer's analysis and determinations and a description of the reviewer's qualifications to the Commissioner, the Company, the Insured, and the Insured's Physician.
5. The Commissioner's written decision to adopt the determination of the Independent Review Organization shall be binding on the Company and the Insured.
6. The cost of the External Independent Medical Review shall be borne by the Company.

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

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

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

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

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

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

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

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

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

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

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review. All utilization review of covered Mental Health and Substance Use Disorder services must be made using the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty or, if outside the scope of any such criteria and guidelines, on current generally accepted standards of Mental Health and Substance Use Disorder care.

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

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

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

Section 14: Online Access to Account Information

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

As part of UnitedHealthcare Student Resources' environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.
My Account now includes a message center - a self-service tool that provides a quick and easy way to view any email notifications the Company may have sent. Notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Profile and making the change there.

Section 15: ID Cards

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

Section 16: UHCSR Mobile App

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

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

Section 17: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

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

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

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

Section 18: Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Out-of-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 an out-of-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 Providers.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call the Company at the number stated on their identification (ID) card to determine which providers participate in the Network.

Out-of-Network Benefits - these benefits apply when the Insured Person decides to obtain Covered Dental Services from out-of-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Out-of-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 an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. Insured Persons may be required to pay an out-of-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 out-of-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, benefits for orthodontic services will be subject to a reduction of up to $500 per occurrence, not to exceed the cost of the benefit to the Company.

Section 2: Benefits for Pediatric Dental Services

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

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

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

Benefits for 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.

Out-of-Network Benefits:

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

Dental Services Deductible

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

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

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

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

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-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**	**Out-of-Network Benefits**
Diagnostic Services - (Not subject to payment of the Dental Services Deductible.)		
Evaluations (Checkup Exams) Except as noted separately below, all evaluations listed below are limited to 2 times per 12 months per provider. 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 D0145 - Oral evaluation for a patient under three years of age and counseling with primary caregiver D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0170 - Re-evaluation - limited, problem focused (Limited to 6 times per 3 months up to a maximum of 12 times per 12 months.) D0171 - Re-evaluation - postoperative office visit D0180 - Comprehensive periodontal evaluation - new or established patient *The following service is not subject to a frequency limit.* D0160 - Detailed and extensive oral evaluation - problem focused, by report	100%	50%
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. D0210 - Intraoral complete series of radiographic images D0709 - Intraoral - complete series of radiographic images - image capture only	100%	50%
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first radiographic image	100%	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**	**Out-of-Network Benefits**
D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal radiographic image D0250 - Intraoral - occlusal radiographic image D0251 - Extra-oral posterior dental radiographic image D0260 - Intraoral - occlusal radiographic image D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only		
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0273 - Bitewings - three radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0708 - Intraoral - bitewing radiographic image - image capture only	100%	50%
The following services are covered when preformed in a dental setting. When services performed in a medical setting, services are covered under the Insured's medical coverage. D0310 - Sialography D0320 - Temporomandibular joint arthrogram, including injection D0322 - Tomographic survey Limited to 1 time per 36 months per provider. D0330 - Panoramic radiograph image D0351 - 3D photographic image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only D0704 - 3-D Photographic image - image capture only	100%	50%
The following service is limited to 2 images per 12 months.	100%	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**	**Out-of-Network Benefits**
D0705 - Extra-oral posterior dental radiographic image - image capture only		
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0601 - Caries risk assessment and documentation, with a finding of low risk D0602 - Caries risk assessment and documentation, with a finding of moderate risk D0603 - Caries risk assessment and documentation, with a finding of high risk D0391 - Interpretation of diagnostic images D0460 - Pulp vitality tests D0470 - Diagnostic casts D0502 - Other oral pathology procedures, by report D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only D0999 - Unspecified diagnostic procedure, by report	100%	50%
Preventive Services - (Not subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to 2 times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	100%	50%
Fluoride Treatments The following services are limited to 2 times every 12 months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride - excluding varnish	100%	50%
The following services are not subject to a frequency limit. D1310 - Nutritional counseling for control of dental disease. D1320 - Tobacco counseling for the control and prevention of oral disease.	100%	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**	**Out-of-Network Benefits**
D1321 - Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use. D1330 - Oral hygiene instructions		
Sealants (Protective Coating) The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	100%	50%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed - unilateral - 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 D1555 - Removal of fixed space maintainer 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	100%	50%
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent	50%	50%

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What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent		
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior) D2390 - Resin-based composite crown, anterior D2391 - Resin-based composite - one surface, posterior D2392 - Resin-based composite - two surfaces, posterior D2393 - Resin-based composite - three surfaces, posterior D2394 - Resin-based composite - four or more surfaces, posterior	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
Except as noted separately below, the following services are subject to a limit of 1 time every 36 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces D2710 - Crown - resin-based composite (indirect) D2712 - Crown - 3/4 resin based composite (indirect) D2721 - Crown - resin with predominantly base metal D2740 - Crown - porcelain/ceramic 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	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**	**Out-of-Network Benefits**
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 The following services are limited to 1 time per 12 months. D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth D2932 - Prefabricated resin crown D2933 - Prefabricated stainless steel crown with resin window The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2915 - Re-cement or re-bond indirectly fabricated or prefabricated post and core D2920 - Re-cement or re-bond crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following service is not subject to a frequency limit. D2950 - Core buildup, including any pins when required	50%	50%
The following services are limited as noted below. D2929 - Prefabricated porcelain/ceramic crown - primary tooth (Limited to 1 time per tooth per 12 months.) D2951 - Pin retention - per tooth, in addition to restoration (Limited to 1 time per tooth every 60 months.)	50%	50%
The following services are 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**	**Out-of-Network Benefits**
D2952 - Cast post and core in addition to crown D2954 - Prefabricated post and core in addition to crown D2970 - Temporary crown (fractured tooth)		
The following services are not subject to a frequency limit. D2941 - Interim therapeutic restoration - primary dentition D2949 - Restorative foundation for an indirect restoration D2950 - Core buildup, including any pins when required D2953 - Each additional indirectly fabricated post - same tooth D2955 - Post removal D2957 - Each additional prefabricated post - same tooth D2971 - Additional procedures to construct new crown under existing partial denture framework The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure D2999 - Unspecified restorative procedure, by report	50%	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D3110 - Pulp cap - direct excluding final restoration D3120 - Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament D3220 - Therapeutic pulpotomy (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit. D3221 - pulpal debridement, primary and permanent teeth D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50%	50%

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What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following services are not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit. D3310 – Endodontic therapy anterior tooth (excluding final restoration) D3320 - Endodontic therapy premolar tooth (excluding final restoration) D3330 - Endodontic therapy molar tooth (excluding final restoration) D3331 - Treatment of root canal obstruction; non-surgical access D3332 - Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth D3333 - Internal root repair of perforation defects 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/pulpal regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit	50%	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy - premolar (first root) D3425 - Apicoectomy - molar (first root) D3426 - Apicoectomy (each additional root) D3430 - Retrograde filling - per root - Surgical procedure for isolation of tooth with rubber dam D3450 - Root amputation - per root D3471 - Surgical repair of root resorption - anterior	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**	**Out-of-Network Benefits**
D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar D3910 - Surgical procedure for isolation of tooth with rubber dam D4381 - Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy D3999 - Unspecified endodontic procedure, by report	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 36 months per quadrant. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following services are limited to 1 every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant D4249 - Clinical crown lengthening - hard tissue	50%	50%
The following services are limited to 1 every 36 months per quadrant.	50%	50%

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What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D4260 - Osseous surgery(including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft - retained natural tooth - first site in quadrant D4265 - Biologic materials to aid in soft and osseous tissue regeneration		
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure	50%	50%
The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure – each additional contiguous tooth D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns	50%	50%
The following services are limited to 1 time per quadrant every 24 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 D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	50%	50%
The following service is not subject to a frequency limit. D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit	50%	50%
The following service is limited to 4 times 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**	**Out-of-Network Benefits**
D4910 - Periodontal maintenance *The following services are not subject to a frequency limit.* D4920 - Unscheduled dressing change (by someone other than treating dentist or their staff) D4999 - Unspecified periodontal procedure, by report		
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 36 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Mandibular 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**	**Out-of-Network Benefits**
D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture (each tooth) D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary 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**	**Out-of-Network Benefits**
frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary denture D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full denture (per arch)		
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
The following service is not subject to a frequency limit. D5862 - Precision attachment, by report	50%	50%
The following services are limited to 1 time per tooth every 60 months. D5863 - Overdenture - complete maxillary D5864 - Overdenture - partial maxillary D5865 - Overdenture - complete mandibular D5866 - Overdenture - partial mandibular	50%	50%
Maxillofacial Prosthetics - (Subject to payment of the Dental Services Deductible.)		

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**	**Out-of-Network Benefits**
The following services are covered when performed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage.		
D5911 - Facial moulage (sectional) D5912 - Facial moulage (complete) D5913 - Nasal prosthesis D5914 - Auricular prosthesis D5915 - Orbital prosthesis D5916 - Ocular prosthesis D5919 - Facial prosthesis D5922 - Nasal septal prosthesis D5923 - Ocular prosthesis, interim D5924 - Cranial prosthesis D5925 - Facial augmentation implant prosthesis D5926 - Nasal prosthesis, replacement D5927 - Auricular prosthesis replacement D5928 - Orbital prosthesis, replacement D5929 - Facial prosthesis, replacement D5931 - Obturator prosthesis, surgical D5932 - Obturator prosthesis, definitive D5933 - Obturator prosthesis, modification D5934 - Mandibular resection prosthesis with guide flange D5935 - Mandibular resection prosthesis without guide flange D5936 - Obturator prosthesis, interim D5937 - Trismus appliance (not for TMD treatment) D5951 - Feeding aid D5952 - Speech aid prosthesis, pediatric D5953 - Speech aid prosthesis, adult D5954 - Palatial augmentation prosthesis D5955 - Palatial lift prosthesis, definitive D5958 - Palatial lift prosthesis, interim D5959 - Palatial lift prosthesis, modification D5960 - Speech aid prosthesis, modification D5982 - Surgical stent D5983 - Radiation carrier D5984 - Radiation shield D5985 - Radiation cone locator D5986 - Fluoride gel carrier D5987 - Commissure splint D5988 - Surgical splint D5991 - Topical Medicament Carrier D5999 - Unspecified maxillofacial prosthesis, by report	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**	**Out-of-Network Benefits**
The following service is not subject to a frequency limit. D5899 - Unspecified removable prosthodontic procedure, by report	50%	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - 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 D6251 - Pontic - resin with predominantly base metal D6721 - Crown - resin with predominantly base metal	50%	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are 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	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**	**Out-of-Network Benefits**
D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal		
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond FPD	50%	50%
The following services are not subject to a frequency limit. D6980 - FPD repair necessitated by restorative material failure D6999 - Unspecified, fixed prosthodontic procedure, by report	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D7111 - Extraction, coronal remnants - deciduous tooth D7140 - Extraction, erupted tooth or exposed root	50%	50%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated 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 D7260 - Oroantral fistula closure - upper molar tooth; extract the tooth - create an opening between sinus D7261 - Primary closure of a sinus perforation	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%

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What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following services are not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth D7283 - Placement of a device to facilitate eruption of impacted tooth D7290 - Surgical repositioning of teeth	50%	50%
The following service is limited to 1 per arch per visit. D7285 - Incisional biopsy of oral tissue - hard (bone, tooth)	50%	50%
The following service is limited to 3 per site per visit. D7286 - Incisional biopsy of oral tissue - soft	50%	50%
The following service is limited to 1 per arch per lifetime. D7291 – Transseptal fiberotomy/supra crestal fiberotomy, by report	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	50%	50%
The following service is limited to 1 per arch per 60 months. D7340 - Vestibuloplasty - ridge extension (secondary epithelialization)	50%	50%
The following service is limited to 1 per arch per lifetime. D7350 - Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment	50%	50%
The following services are not subject to a frequency limit D7410 - Excision of benign lesion up to 1.25 cm	50%	50%

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What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D7411 - Excision of benign lesion greater than 1.25 cm D7412 - Excision of benign lesion, complicated D7413 - Excision of malignant lesion up to 1.25 cm D7414 - Excision of malignant lesion greater than 1.25 cm D7415 - Excision of malignant lesion, complicated D7440 - Excision of malignant tumor-lesion diameter up to 1.25 cm D7441 - Excision of malignant tumor - lesion diameter greater than 1.25 cm D7450 - Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm D7451 - Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm D7460 - Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm D7461 - Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm		
The following services are covered when performed in a dental setting. When services performed in a medical setting services are covered under your medical coverage. D7465 - Destruction of lesion(s) by physical or chemical method, by report D7490 - Radical resection of maxilla or mandible	50%	50%
The following services are not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible) D7472 - Removal of torus palatinus D7473 - Removal of torus mandibularis D7485 - Surgical reduction of osseous tuberosity	50%	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess, intraoral soft tissue D7511 - Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) D7520 - Incision and drainage of abscess - extraoral soft tissue	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**	**Out-of-Network Benefits**
D7521 - Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) D7530 - Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue D7540 - Removal of reaction-producing foreign bodies - musculoskeletal system D7550 - Partial ostectomy/sequestrectomy for removal of non-vital bone D7560 - Maxillary sinusotomy for removal of tooth fragment or foreign body D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Ligual frenectomy (frenulectomy) D7963 - Frenuloplasty D7970 - Excision of hyperplastic tissue - per arch D7972 - Surgical reduction of fibrous tuberosity D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7971 - Excision of pericoronal gingiva		
The following services are covered when performed in a dental setting. When services performed in a medical setting services are covered under your medical coverage. D7610 - Maxilla - open reduction (teeth immobilized, if present) D7620 - Maxilla - closed reduction (teeth immobilized, if present) D7630 - Mandible - open reduction (teeth immobilized, if present) D7640 - Mandible - closed reduction (teeth immobilized, if present) D7650 - Malar and/or zygomatic arch - open reduction D7660 - Malar and/or zygomatic arch - closed reduction D7670 - Alveolus - closed reduction, may include stabilization of teeth D7671 - Alveolus - open reduction, may include stabilization of 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**	**Out-of-Network Benefits**
D7680 - Facial bones - complicated reduction with fixation and multiple surgical approaches D7710 - Maxilla - open reduction D7720 - Maxilla - closed reduction D7730 - Mandible - open reduction D7740 - Mandible - closed reduction D7750 - Malar and/or zygomatic arch - open reduction D7760 - Malar and/or zygomatic arch - closed reduction D7770 - Alveolus, open reduction stabilization of teeth D7771 - Alveolus, closed reduction stabilization of teeth D7780 - Facial bones - complicated reduction with fixation and multiple surgical approaches D7810 - Open reduction of dislocation D7820 - Closed reduction of dislocation The following services are covered when performed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage. D7830 - Manipulation under anesthesia D7840 - Condylectomy D7850 - Surgical discectomy, with/without implant D7852 - Disc repair D7854 - Synovectomy D7856 - Myotomy D7858 - Joint reconstruction D7860 - Arthrotomy D7865 - Arthroplasty D7870 - Arthrocentesis D7871 - Non-arthroscopic lysis and lavage D7872 - Arthroscopy - diagnosis, with or without biopsy D7873 - Arthroscopy - surgical: lavage and lysis of adhesions D7874 - Arthroscopy - surgical: disc repositioning and stabilization D7875 - Arthroscopy - surgical: synovectomy D7876 - Arthroscopy - surgical: discectomy D7877 - Arthroscopy - surgical: debridement D7880 - Occlusal orthotic device, by report D7899 - Unspecified TMD therapy, by report		

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**	**Out-of-Network Benefits**
D7911 - Complicated suture - up to 5 cm D7912 - Complicated suture - greater than 5 cm. D7920 - Skin graft (identify defect covered, location and type of graft) D7940 - Osteoplasty - for orthognathic deformities D7941 - Osteotomy - mandibular rami D7943 - Osteotomy - mandibular rami with bone graft; includes obtaining the graft D7944 - Osteotomy - segmented or subapical - per sextant or quadrant D7945 - Osteotomy - body of mandible D7946 - LeFort I (maxilla - total) D7947 - LeFort I (maxilla - segmented) D7948 - LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)- without bone graft D7949 - LeFort II or LeFort III - with bone graft D7950 - Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report D7951 - Sinus augmentation with bone or bone substitutes D7952 - Sinus augmentation via a vertical approach D7955 - Repair of maxillofacial soft and/or hard tissue defect D7980 - Sialolithotomy D7981 - Excision of salivary gland, by report D7982 - Sialodochoplast D7983 - Closure of salivary fistula D7990 - Emergency tracheotomy D7991 - Coronoidectomy D7995 - Synthetic graft - mandible or facial bones, by report D7997 - Appliance removal (not by dentist who placed appliance), includes removal of archbar D7999 - Unspecified oral surgery procedure, by report D9410 - House/extended care facility call D9420 - Hospital call D9440 - Office visit for observation (during regularly scheduled hours) - no other services performed		
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit; however, the	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**	**Out-of-Network Benefits**
service is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure D9120 - Fixed partial denture sectioning D9210 - Local anesthesia not in conjunction with operative or surgical procedures D9211 - Regional block anesthesia D9212 - Trigeminal division block anesthesia D9215 - Local anesthesia in conjunction with operative or surgical procedures D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9230 - Inhalation of nitrous oxide/analgesia, anxiolysis D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9243 - Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment D9248 - Non-intravenous moderate (conscious) sedation D9430 - Office visit for observation (during regularly scheduled hours) - no other services performed D9610 - Therapeutic parenteral drug single administration D9612 - Therapeutic parenteral drugs - two or more D9910 - Application of desensitizing medicament D9930 - Treatment of complications (post-surgical) - unusual circumstances, by report D9999 - Unspecified adjunctive procedure, by report D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)		
The following are limited to 1 guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch	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**	**Out-of-Network Benefits**
D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch D9950 - Occlusion analysis - mounted case D9951 - Occlusal adjustment - limited D9952 - Occlusal adjustment - complete		
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement: transosteal implant D6110 - Implant/abutment supported removable denture for edentulous arch - maxillary D6111 - Implant/abutment supported removable denture for edentulous arch - mandibular D6112 - Implant/abutment supported removable denture for partially edentulous arch - maxillary D6113 - Implant/abutment supported removable denture for partially edentulous arch - mandibular D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown	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**	**Out-of-Network Benefits**
D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6114 - Implant/abutment supported fixed denture for edentulous arch - maxillary D6115 - Implant/abutment supported fixed denture for edentulous arch - mandibular D6116 - Implant/abutment supported fixed denture for partially edentulous arch - maxillary D6117 - Implant/abutment supported fixed denture for partially edentulous arch - mandibular 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		

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**	**Out-of-Network Benefits**
D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6092 - Re-cement or rebond implant/abutment supported crown D6093 - Re-cement or re-bond implant/abutment supported fixed partial denture D6094 - Abutment supported crown - titanium and titanium alloys D6095 - Repair implant abutment, by report 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 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of 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 - Radiographic/surgical implant index, by report		

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**	**Out-of-Network Benefits**
D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6194 - Abutment supported retaininer crown for FPD - titanium D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys D6199 - Unspecified implant procedure, by report		
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for comprehensive orthodontic treatment are approved by the Company, when Necessary to promote oral health, restore oral structures to health and function, and to treat emergency conditions. Benefits are also provided for all medically handicapping malocclusions, regardless of cause, including Injury. All orthodontic treatment must be prior authorized. See the "Does Pre-Authorization Apply?" provision for details regarding applicable penalty for failure to obtain pre-authorization. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.		
The following services are not subject to a frequency limitation. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8681 - Removable orthodontic retainer adjustment 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	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**	**Out-of-Network Benefits**
D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment mandibular D8703 - Replacement of lost or broken retainer - maxillary D8704 - Replacement of lost or broken retainer - mandibular D8999 - Unspecified orthodontic procedure, by report		

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

Section 3: Pediatric Dental Exclusions

These exclusions apply specifically to Pediatric Dental benefits included in this provision. They do not apply to any Covered Medical Expenses provided elsewhere in the Policy.

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

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease, condition or Injury.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition. The Insured may request an Independent Medical Review (IMR) from the California Department of Insurance (CDI) at no cost to the Insured as described in the Notice of Appeal Rights section of the Policy.
8. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
9. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
10. 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.
11. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
12. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
13. 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.
14. 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.
15. Foreign Services are not covered unless required for a Dental Emergency.
16. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
17. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
18. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from an out-of-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 written proof covering the occurrence, the character, and the extent of the loss.

In order to provide proof of the extent of the loss, the proof of loss may need to include some or 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 the number 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 Out-of-Network Benefits, when Covered Dental Services are received from out-of-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 Out-of-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.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

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

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

Out-of-Network Benefits - benefits available for Covered Dental Services obtained from out-of-Network Dentists.

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

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

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

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

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

Section 19: Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network or an out-of-Network Vision Care Provider. To find a UnitedHealthcare Vision Network 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 UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhcvision.com.

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

When obtaining these Vision Care Services from a UnitedHealthcare Vision Network 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.

Out-of-Network Benefits:

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

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

Policy Deductible

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

What Are the Benefit Descriptions?

Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and out-of-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.
- Dilation, if professionally indicated.

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 chooses 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 UnitedHealthcare Vision Network 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 chooses 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 UnitedHealthcare Vision Network Vision Care Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

Contact Lenses

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

Benefits include the fitting/evaluation fees, 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 per year. If the Insured Person chooses more than one of these Vision Care Services, the Company will pay benefits for only one Vision Care Service.

Necessary Contact Lenses

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

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

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

Low Vision

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

Benefits include:

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

Schedule of Benefits

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	50% of the billed charge.
• Bifocal		100% after a Copayment of $40.	50% of the billed charge.
• Trifocal		100% after a Copayment of $40.	50% of the billed charge.
• Lenticular		100% after a Copayment of $40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.
• Each of the following is a separate charge shown under columns		20%	20% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Network and Non-Network Benefits: ▪ Blended segment lenses, ▪ Intermediate vision lenses. ▪ Standard Progressives. ▪ Premium Progressives ▪ Photochromic Glass ▪ Plastic Photosensitive ▪ Polarized ▪ Hi-Index ▪ Standard Anti-Reflective Coating ▪ Premium Anti-Reflective Coating ▪ Ultra Anti-Reflective Coating			
• UV Coating		20%	20% of the billed charge.
• Glass-grey #3 prescription sunglass lenses		20%	20% of the billed charge.
• Tint		20%	20% of the billed charge.
• Oversized lenses		20%	20% of the billed charge.

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

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-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 per year.	100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply per year.	100% after a Copayment of $40.	50% of the billed charge.
Low Vision Care Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.			
• Comprehensive low vision evaluation	Limited to once every 60 months.	100% of the billed charge.	75% of the billed charge.
• Low vision testing		100% of the billed charge.	75% of the billed charge.
• Low vision therapy		100% of the billed charge.	75% of the billed charge.
• Low vision aids		100% of the billed charge.	75% of the billed charge.
• Follow-up Care	Limited to 4 visits every 60 months.	100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

These exclusions apply specifically to Pediatric Vision Care Services benefits included in this provision. They do not apply to any Covered Medical Expenses provided elsewhere in the Policy.

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

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in Section 1: Benefits for Pediatric 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 an out-of-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 provided by an out-of-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a UnitedHealthcare Vision Network Vision Care Provider or an out-of-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 UnitedHealthcare Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

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

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

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

Section 20: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

Important Notice: This plan covers all Medically Necessary Prescription Drug Products, including Prescription Drug Products not listed in the Prescription Drug List (PDL), determined to be Medically Necessary, and disposable devices for administration. Any limitation or utilization management shall be consistent with and based on clinical guidelines and peer-reviewed scientific and medical literature.

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 either show their ID card to the Network Pharmacy when the prescription is filled or provide the Network Pharmacy with identifying information that can be verified by the Company during regular business hours. If the Insured does not show their ID card to the Network Pharmacy or provide verifiable information, they will need to pay for the Prescription Drug at the pharmacy.

The Insured may then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting www.uhcsr.com and logging in to their online account or by calling *Customer Service* at 1-855-828-7716.

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

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

Copayment and/or Coinsurance Amount

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

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

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

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

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

How Do Supply Limits Apply?

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

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

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy 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 a supply limit for dispensing by contacting the Company at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

What Happens When a Brand-name Drug Becomes Available as a Generic?

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

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular reference product. This provision does not apply in the case of drugs that have already been approved and continue to be appropriately prescribed and are considered to be safe and effective for use.

Designated Pharmacies

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

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Pharmacy, the Insured may opt-out of the Designated Pharmacy program at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, the Insured will be responsible for the entire cost of the Prescription Drug Product.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, no benefits will be paid for that Prescription Drug Product.

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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.

Do Prior Authorization Requirements Apply?

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 Drug Products requiring prior authorization are subject, from time to time, to the Company's review and change. There may be certain Prescription Drug Products that require the Insured to notify the Company directly rather than the Insured's Physician or pharmacist. The Insured may

determine whether a particular Prescription Drug requires prior authorization at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

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

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

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

Does Step Therapy Apply?

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

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

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

If the Insured Person is changing policies, we will not require the Insured Person to repeat step therapy when the Insured Person is already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for the Insured Person's medical condition. However, we may impose prior authorization requirements for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy requirements imposed by the former policy. The prescribing provider may also prescribe another Prescription Drug Product covered under this Policy that is medically appropriate for the Insured Person's medical condition. The Insured may find out whether a particular Prescription Drug Product is subject to step therapy requirements at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

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

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

When Does the Company Limit Selection of Pharmacies?

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

Coverage Policies and Guidelines

The Company’s Prescription Drug List (PDL) Management Committee makes tier placement changes on the Company’s behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include,

but are not limited to, the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

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

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

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

Rebates and Other Payments

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

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

Definitions

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

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

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

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

Exceptions:

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

If the Company denies benefits because it was determined that the treatment is not Medically Necessary or was an Experimental or Investigational Service, the Insured may request an Independent Medical Review from the California Department of Insurance (CDI) at no cost to the Insured Person.

Generic means a Prescription Drug Product: (1) that is Therapeutically 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 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.

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

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 described in the Preventive Care Services provision in this Certificate and required by applicable law under any of the following:

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

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

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

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

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

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 generally 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.
- Certain injectable medications administered at 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 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.

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

Therapeutically Equivalent means when Prescription Drugs Products contain the same amount of the same active ingredient as a brand name drug and are the same as a brand name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use.

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

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

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

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

If the Company denies benefits because it was determined that the treatment is not Medically Necessary or was an Unproven Service, the Insured may request an Independent Medical Review from the California Department of Insurance (CDI) at no cost to the Insured Person.

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. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay and which are covered under the Medical Expense Benefits section of this Certificate.
4. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
   This exclusion does not apply to drugs approved by the U.S. Food and Drug Administration which are prescribed for either of the following:

a. To treat cancer during certain clinical trials as described in the Policy.
b. For a use that is different from the use for which the U.S. Food and Drug Administration approved it, when needed for treatment of a chronic and seriously debilitating or life-threatening condition. The drug must be recognized for the specific treatment for which the drug is being prescribed by any of the following:
   i. The American Hospital Formulary Service's Drug Information.
   ii. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
      1) Elsevier Gold Standard's Clinical Pharmacology.
      2) National Comprehensive Cancer network Drug and Biologics Compendium.
      3) Thomson Microdex DrugDex.
   iii. It is recommended by two articles from major peer reviewed medical journals.

This exception does not provide coverage for any drug that the U.S. Food and Drug Administration or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government (for example, Medicare), except as otherwise provided by law.
6. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are provided under any workers' compensation law or other similar laws.
7. A pharmaceutical product for which benefits are provided in the Medical Expense Benefits section of this Certificate of Coverage.
8. General vitamins, except the following, which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.
9. Unit dose packaging or repackagers of Prescription Drug Products. This exclusion does not apply to products that are only commercially available as repackaged or unit dose packaged products.
10. 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.)
11. 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 have essentially the same efficacy and adverse effect profile to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
    Over-the-counter drugs and devices prescribed by a Physician for preventive care services are provided as required under the Preventive Care Services benefit.
12. 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. This exclusion does not apply to Medically Necessary services to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU). This exclusion does not apply to nutritional or dietary supplements that must be covered as preventive care (e.g., fluoride supplements, folic acid supplements).
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 or in the Benefits for Diabetes provision in the Mandated Benefits section of this Certificate of Coverage. This does not apply to covered insulin pumps and related supplies that are distributed exclusively through pharmacy channels.
15. Diagnostic kits and products, including associated services. This exclusion does not apply to the Benefits for Home Test Kits for Sexually Transmitted Diseases provision in the Mandated Benefits section of this Certificate of Coverage.
16. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill. This exclusion does not apply to the Preventive Care Services benefit in the Medical Expense Benefits section of this Certificate of Coverage.

Right to Request Coverage of a Medically Necessary Prescription Drug Not Listed on the Prescription Drug List

When a Prescription Drug Product is not listed on the Prescription Drug List, the Insured Person or the Insured's representative may request an exception to gain access to the 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.

Please note, if the request for an exception is approved, the Insured may be responsible for paying the applicable Copayment and/or Coinsurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the Schedule of Benefits.

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 Company denies benefits because it was determined that the treatment is not Medically Necessary or was an Experimental or Investigational Service or Unproven Service, the Insured may request an Independent Medical Review (IMR) from the California Department of Insurance (CDI) at no cost to the Insured.

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

Schedule of Benefits

CALIFORNIA INSTITUTE OF THE ARTS

2023-756-1

METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 87.580%

Injury and Sickness Benefits

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

Deductible Preferred Provider	$150 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	50% except as noted below
Out-of-Pocket Maximum Preferred Provider	$6,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	$7,500 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$12,000 (Per Insured Person, Per Policy Year)

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

The **Preferred Provider** for this plan is UnitedHealthcare Choice Plus.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider. Refer to the Preferred Provider and Out-of-Network Provider Information section of the Certificate for information on reimbursement for Emergency Services provided by an Out-of-Network Provider, Covered Medical Expenses provided at Preferred Provider facilities at which, or as a result of which, the services are performed by an Out-of-Network Physician, and Air Ambulance transport provided by an Out-of-Network Provider.

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

Out-of-Country Claims:
Covered Medical Expenses for services received outside the U.S. will be paid as follows:

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

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 Provider unless otherwise specifically stated. Please refer to the Medical Expense Benefits 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 Benefits	Out-of-Network Provider Benefits
Room and Board Expenses	$50 Copay per Hospital Confinement 80% of Allowed Amount not subject to Deductible	50% of Allowed Amount after Deductible
Intensive Care	$50 Copay per Hospital Confinement 80% of Allowed Amount not subject to Deductible	50% of Allowed Amount after Deductible
Hospital Miscellaneous Expenses	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Private Duty Nurse's Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Physician's Visits	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Day Surgery Miscellaneous	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Physician's Visits	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	50% of Allowed Amount after Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$150 Copay per visit 80% of Allowed Amount not subject to Deductible	$150 Copay per visit 80% of Allowed Amount not subject to Deductible (The Insured's expense shall not exceed the amount payable for Preferred Provider Medical Emergency Expenses.)
Diagnostic X-ray Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Radiation Therapy	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Laboratory Procedures	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Tests & Procedures	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Injections	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Chemotherapy	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Prescription Drugs	UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $10 Copay per prescription Tier 1 $30 Copay per prescription Tier 2 $50 Copay per prescription Tier 3 up to a 30-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay and/or Coinsurance (up to 50% of the Prescription Drug Charge). 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.	$10 Copay per prescription generic drug $30 Copay per prescription brand-name drug up to a 30-day supply per prescription not subject to Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	80% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible (The Insured's air ambulance expense shall not exceed the amount payable for Preferred Provider air ambulance services.)
Durable Medical Equipment See also Benefits for Prosthetic Devices for Speaking Post Laryngectomy in the Mandated Benefits Section of the Certificate	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Consultant Physician Fees	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	50% of Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Natural Teeth or as specifically provided in the Certificate only.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Mental Illness Treatment See Benefits for Mental Health and Substance Use Disorders in the Mandated Benefits Section of the Certificate.	**Inpatient:** 80% of Allowed Amount not subject to Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 80% of Allowed Amount after Deductible	**Inpatient:** 50% of Allowed Amount after Deductible **Outpatient office visits:** 50% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 50% of Allowed Amount after Deductible
Substance Use Disorder Treatment See Benefits for Mental Health and Substance Use Disorders in the Mandated Benefits Section of the Certificate.	**Inpatient:** 80% of Allowed Amount not subject to Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 80% of Allowed Amount after Deductible	**Inpatient:** 50% of Allowed Amount after Deductible **Outpatient office visits:** 50% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 50% of Allowed Amount after Deductible
Maternity (Routine pre-pregnancy, pre-natal, post-partum and inter-pregnancy office visits (office visits not related to Complications of Pregnancy) and all recommended preventive items and services related to pregnancy are provided under Preventive Care Services.)	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. See Preventive Care Services benefit in the Medical Expense Benefits section of the Certificate.	100% of Allowed Amount not subject to Deductible	50% of Allowed Amount after Deductible
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes in the Mandated Benefits Section of the Certificate.	Paid as any other Sickness	Paid as any other Sickness
Home Health Care 100 visits maximum per Policy Year	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Hospice Care	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Inpatient Rehabilitation Facility	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Skilled Nursing Facility	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Urgent Care Center	$20 Copay per visit 80% of Allowed Amount not subject to Deductible	50% of Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	80% of Allowed Amount after Deductible	50% of Allowed Amount 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
Abortion and Abortion Related Services	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount not subject to Deductible
Acupuncture Services	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Bariatric Surgery	Paid as any other Sickness	Paid as any other Sickness
Medical Foods See also Benefits for Phenylketonuria in the Mandated Benefits Section of the Certificate.	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Ostomy and Urological Supplies	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible
Vision Correction	80% of Allowed Amount after Deductible	50% of Allowed Amount after Deductible

UNITEDHEALTHCARE INSURANCE COMPANY

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE PROGRAM

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does not discriminate or treat Insureds differently on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

If you think you were treated unfairly for any of these reasons, 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.

If you think you were treated unfairly because of your ancestry, religion, marital status, gender, gender identity, or sexual orientation, you can also send a complaint to the California Department of Insurance:

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, 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

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 ကိုခေါ် ပါ။

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

Cherokee
ᏕᏒᏂᎯᏍᏗ ᎤᏬᏝᏍᏚᏗ ᎤᏬᏝᏡᎬᎢ ᏂᎯ ᏒᏩᏟᏅᎢᏍᏓᏗᎸᎢ ᏂᏓᎬᏩᏟᎾ ᎠᏎᏍᎢ. ᎨᏩᏍ ᎠᏂ ᏯᏏᎳᏟᏭ 1-866-260-2723.

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

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

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

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

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

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

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

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

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

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

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

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

Ibo
Enyemaka na-ahazi asusụ, 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
ကျိာ်တၢ်မၤစၢၤအကိၢ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိဉ်ဟ့ဉ်အပ့ၢ်ဘဉ်(ခီလိ)န့ၣ်လီၤ.
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 ı nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

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

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

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

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

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

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

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 maada. 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
ܚܕܡܬ̈ܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܛܝܒܐܝܬ، ܡܓܢ ܗܘܝܐ ܩܐܠܘܟܘܢ. ܒܒܥܘܬܐ،
ܩܪܘ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

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

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

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 1-866-260-2733

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

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

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

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

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

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

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

Yoruba
Isẹ iranlọwọ ẹdẹ ti ọ jẹ ọfẹ, wa fun ọ. Pe 1-866-260-2723